Resident Physician

journal for the Hospital Resident

Dec.

the high cost of bad habits: gastric hyperacidity

Hurried meals and tense days exact their price in short order. Gastric hyperacidity—whether acute or chronic—can, however, be relieved quickly and pleasantly with Gelusil.

Awake or asleep, the patient is protected: The sustained action of magnesium trisilicate and specially prepared aluminum hydroxide gel restores and maintains a mildly acid gastric pH, without overneutralizing or alkalizing. With Gelusil, the twin dangers of acid rebound and systemic alkalosis are thus avoided.

A new formulation, Gelusil-Lac, now combines the proven antacid action of Gelusil with the sustained buffering effect of specially prepared high-protein (low-fat) milk solids. The formula is designed to *prevent* the onset of gastric pain, particularly "middle-of-the-night" attacks.

Nonconstipating: The aluminum hydroxide component in Gelusil assures a low aluminum ion concentration; hence the formation of astringent—and constipating—aluminum chloride is minimal.

Dosage: 2 Gelusil tablets or 2 teaspoonfuls of Gelusil liquid two hours after eating or when symptoms are pronounced. Each tablet or teaspoonful provides: 7½ gr. magnesium trisilicate and 4 gr. aluminum hydroxide gel. Gelusil-Lac: at bedtime, one heaping tablespoonful stirred rapidly into one-half glass (4 fl. oz.) of cool water. (Provides equivalent of 4 Gelusil tablets.)

Gelusil®/Gelusil-Lac

WARNER-CHILCOTT

100 YEARS OF SERVICE TO THE MEDICAL PROFESSION

December 1956, Vol. 2, No. 12

Contents

Resident Physician

December 1956, Vol. 2, No. 12

Articles

The Resident Physician is published monthly on the fifteenth by The Resident, Inc., with publication offices at 34 North Crystal Street, East Stroudsburg, Pennsylvania. Executive, advertising and editorial offices at 1447 Northern Boulevard, Manhasset, New York. Acceptance under section 34.64 authorized. Postmaster: If undelivered, please send form 3579 to Resident Physician, 1447 Northern Boulevard, Manhasset, New York.

Contents

Resident Physician

Departments

a ***new*** *gerontotherapeutic preparation*

Post-Surgery
Convalescence
Debilitating Disease
Fatigue

Neurasthenia
Poor Nutrition
Emotional Tension
Mental Depression

VISTABOLIC®

The clinical picture of the geriatric patient may be said to be the sum total of decades of stresses and strains. Vistabolic® is a new gerontotherapeutic preparation designed to help geriatric patients bridge periods of unusual stress. It combines both anabolic and adrenal hormones with Vitamin B_{12} with Intrinsic Factor Concentrate in oral tablets, and anabolic and adrenal hormones with high concentrate Liver Injection, U.S.P. in the parenteral form. These ingredients provide the geriatric patient with direct support in areas where deficiencies are likely to occur during stressful situations.

Each oral tablet provides:

Hydrocortisone ..... 1.0 mg.
Stenediol® (Methandriol) .. 10.0 mg.
Bifacton® (Vitamin B_{12} w/Intrinsic Factor Concentrate) ..... ½ U.S.P. oral unit

← *anti-stress aid* →
← *anabolic aid* →
← *nutritional aid* →

Each cc provides:

Hydrocortisone acetate ..... 1.0 mg.
Stenediol® (Methandriol) .. 10.0 mg.
Vitamin B_{12} activity (Pernaemon® Liver Injection, U.S.P.) ..... 20.0 mcg.

Available in 10-cc vials and boxes of 30 tablets

Professional literature available on request

Organon inc. **ORANGE, N. J.**

December 1956, Vol. 2, No. 12

Journal for the Hospital Resident

Resident Physician

December 1956, Vol. 2, No. 12

Articles are accepted for publication with the understanding that they are contributed solely to this publication, and will directly interest or be of practical value to resident physicians. When possible, two copies of the manuscript should be submitted. Articles with photographs, illustration or drawings are especially desired.

RESIDENT PHYSICIAN

Randolph Morando, Business Manager and Secy.;
William Leslie, 1st Vice President;
Roger Mullaney, 2nd Vice President;
Walter J. Biggs, Sales and Advertising.
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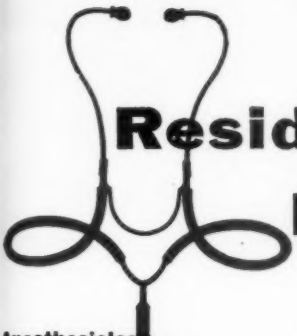


Resident Physician

Advisory Board

criteria for skeletal muscle relaxan

"To date, there has been no available drug proved sufficiently safe, effective or long-lasting to justify its general use."[1]

Before Flexin

NOW

flexin*

(Zoxazolamine,† McNeil)

fulfills these requirements

FLEXIN is sufficiently safe

"...no important signs of toxicity were found in blood or urine studies..."[2]

FLEXIN is effective

"Rheumatic diseases with the major disability caused by stiffness and aching appear to respond well..."[3]

FLEXIN has a long duration of action

"Some degree of muscular relaxation [with FLEXIN] was occasionally seen 24 hours or longer after discontinuance of therapy."[1]

supplied: 250 mg. yellow, scored tablets, bottles of 50.

(1) Abrahamsen, E. H., and Baird, H. W., III: J.A.M.A. 160:749 (Mar. 3) 1956. (2) Rodriguez-Gomez, M.; Valdes-Rodriguez, A., and Drew, A. L.: J.A.M.A. 160:752 (Mar. 3) 1956. (3) Smith, R. T.; Kron, K. M.; Peak, W. P., and Hermann, I. F.: J.A.M.A. 160:745 (Mar. 3) 1956.

McNEIL LABORATORIES, INC • PHILADELPHIA 32, PA. McNEIL

*T.M. †U.S. Patent Pending

why 'Neosporin' is so widely used in dermatologic and ophthalmic infections...

1 ***Because it provides a broader spectrum of bactericidal activity than is available from any single agent.***

The first principle of treating bacterial infections of the skin and eyes (where secondary invaders must be considered as well as the original pathogen) is to use antibacterial therapy of the widest possible scope.

'Neosporin' is the most effective combination of bactericidal agents known for the eradication of bacteria commonly present in topical infections.

2 ***Because its use spares the patient sensitization — in two ways...***

a. Development of local allergic reaction to any of the antibiotics in 'Neosporin' is rare.

b. None of the antibiotics in 'Neosporin' is widely used systemically. Choosing 'Neosporin' for topical infections saves sensitizing the patient to other antibiotics which he may subsequently need for a systemic infection.

SAFE ■ BACTERICIDAL ■ BLAND

'NEOSPORIN'® brand

ANTIBIOTIC OINTMENT

Polymyxin B—Bacitracin—Neomycin

Tubes of ½ oz. and 1 oz. with applicator tips, and ⅛ oz. with ophthalmic tip.

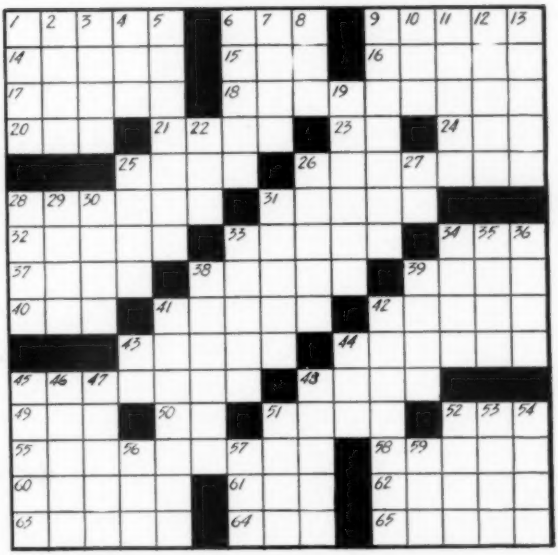
ANTIBIOTIC OPHTHALMIC SOLUTION

Polymyxin B—Gramicidin—Neomycin

Bottles of 10 cc. with sterile dropper.

BURROUGHS WELLCOME & CO. (U. S. A.) INC., Tuckahoe, New York

(Answer on page 112)

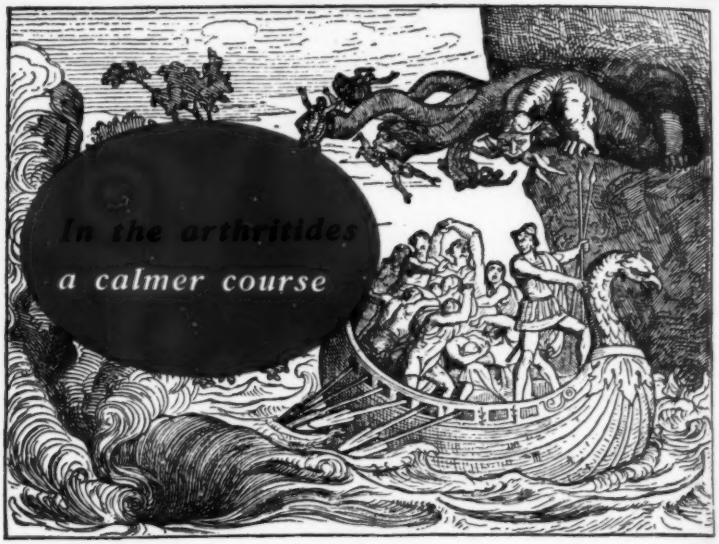


ACROSS

1. Filterable agent in disease
4. Common Trichina Host
9. Litmus——
14. Gruel made of maize meal (Sp. Amer.)
15. —— Serrata
16. Oil formerly used to treat ulcers
17. The body's largest gland
18. Inflammation of the stomach
19. Compass direction (abbr.)
20. Resound
21. Right (abbr.)
22. Malt beverage
23. Represent in drawing
24. Rubeola
25. Prescribed amount of medicine
26. Swollen
27. Texas mission besieged in 1836
28. Large intestine
29. Male offspring
30. Monetary penalty
31. Faux pas (slang)
32. Half (prefix)
33. Pedal digit
34. L'Hotel Dieu is here
35. Pertaining to the eye
36. Pertaining to the Ilium
37. Narcotic
38. Induct into office
40. Abdominal fat of a ruminant
41. A marshal of France
42. Symbol for neon
43. —— Price test for vitamin A in oils
44. Ulmus
45. Biotypes
46. Cessation of respiration
47. Hawaiian shrub used for making nets
48. Biblical high priest
49. Entire
50. Tether (obs. var.)
51. Sebaceous cyst
52. Put forth, as effort

DOWN

1. Farewell (L.)
2. Inflammation (suffix)
3. Wander
4. Diminutive suffix for noun
5. Creeping eruption
6. Golf's "Ben"
7. Relating to the mouth
8. Nitrous oxide is one
9. Relate
10. Mohammed's son-in-law
11. Member of a corolla (Botani)
12. Zola's given name
13. What the temperature does in pneumonia
19. A Parkinsonian has this
22. ——tic; Ipecac is one
25. Physically disabled
26. Stubborn ones
27. Sine Die (Abbr.)
28. Foolish
29. Medley
30. Mentally sound
31. Characterized by continuous tension
33. Skeleton of marine coelenterates
34. Bristle
35. Leave out
36. Fastidious
38. Hyde——; American botanist
39. Expectorate
41. Relating to the sole of the foot
42. Perform surgery
43. Pronoun
44. Possessive pronoun
45. Cast metal mass
46. Darnel (local U.S.)
47. An ecclesiastical council
48. The black buck of India
51. Suffix denoting a swelling
52. Grafted (Her.)
53. Shakespearean king
54. The seed of barley
56. Unit
57. Church bench
59. An eruptive disease



Ulysses between Scylla and Charybdis—Bettmann Archive

between the hazards of high steroid dosage and the frustration of inadequate relief

Because of the complementary action of cortisone and the salicylates, Salcort produces a greater therapeutic response with lower dosage. Side effects are not encountered, and no withdrawal problems have been reported.

One study concludes: "Salicylate potentiates the greatly reduced amount of cortisone present so that its full effect is brought out without evoking undesirable side reactions."[1]

SALCORT®*

indications:

Rheumatoid arthritis . . . Rheumatoid spondylitis . . . Rheumatic fever . . . Bursitis . . . Still's Disease . . . Neuromuscular affections

each tablet contains:

Cortisone acetate	2.5 mg.
Sodium salicylate	0.3 Gm.
Aluminum hydroxide gel, dried	0.12 Gm.
Calcium ascorbate. . . . (equivalent to 50 mg. ascorbic acid)	60.0 mg.
Calcium carbonate . . .	60.0 mg.

[1] *Busse, E.A.: Treatment of Rheumatoid Arthritis by a Combination of Cortisone and Salicylates. Clinical Med.* 11:1105

*U.S. Pat. 2,691,662

The S. E. MASSENGILL COMPANY, Bristol, Tennessee • New York • Kansas City • San Francisco

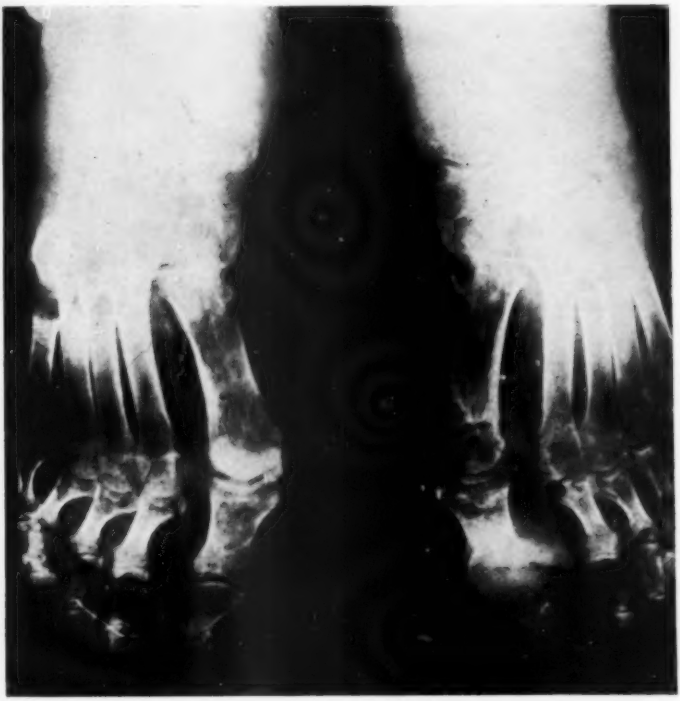
Viewbox Diagnosis

Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center

Which Is Your Diagnosis?

1. Osteoarthritis
2. Reynaud's disease
3. Trauma
4. Gout

(Answer on page 112)



Life without Frenzy

He used to fuss and fume when traffic slowed him down. Now he relaxes—his pace of living has been "calmed down"—since his doctor prescribed

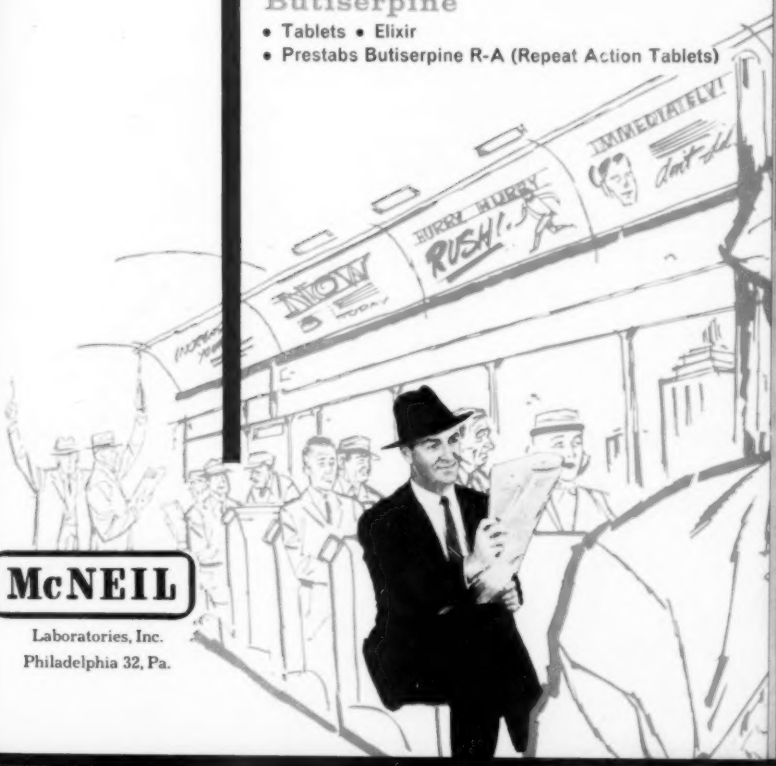
Butiserpine®

That's the tranquilizing-sedative-hypotensive effect BUTISERPINE has on tense, highstrung patients. Its *Butisol* component quickly induces a more reasonable, tranquil attitude. This gives the *reserpine* component a chance to build up to its maintenance tranquilizing effect.

Now you can prescribe Butiserpine also in its delightful Elixir form. Each tablet or teaspoonful of elixir contains:

Butisol® Sodium 15 mg. (¼ gr.)
(Sodium 5-ethyl-5-sec-butyl barbiturate, McNeil)
Reserpine 0.1 mg.

Butiserpine
- Tablets • Elixir
- Prestabs Butiserpine R-A (Repeat Action Tablets)



McNEIL
Laboratories, Inc.
Philadelphia 32, Pa.

Letters to the Editor

Unsigned letters will neither be published nor read. However, at your request your name will be withheld.

Miss Any Copies?

I wish to express my deepest appreciation for the wonderful service of the RESIDENT PHYSICIAN which I have received regularly for the past year. It indeed furnishes the information that most hospital residents desire and can't get elsewhere. I am sure it is the most popular journal among residents and interns.

I have changed my address. Will I miss any copies?

Emanuel Y. Li, M.D.
Homer Folks Tuberculosis Hospital
Oneonta, New York

● *Please give us 5 weeks to effect address changes. If you do miss an issue, drop us a card promptly; we'll see that you are filled in if there are copies available.*

State Boards

As an American student in contact with numerous foreign medical graduates, I am continually asked about state board examinations for foreign graduates, reciprocity of various states, etc. I am not clear on this subject and think it would provide interesting and informative articles for RESIDENT PHYSICIAN.

N. Pozer
Flower and Fifth Ave. Hospitals
New York, New York

● *We are just getting clear on the subject ourselves at the moment and will try to come up with an accurate report in an early issue.*

Back Copies

I will finish my Ob-Gyn residency training in June 1957 and am now making plans to build and equip an office so as to open a practice in Ob-Gyn in the summer of 1957.

I am unable to locate the issue of RESIDENT PHYSICIAN from early in 1956 containing an article "Equip-

—Concluded on page 26

if he's coughing:

AMBENYL

EXPECTORANT

AMBENYL EXPECTORANT has achieved an outstanding record for cough relief because it is equally effective in coughs occurring with colds and in those where allergy may be a factor. Comprehensive in formulation, AMBENYL EXPECTORANT includes selected demulcent and expectorant agents, plus Ambodryl,® for potent antihistaminic action, and Benadryl,® for antihistaminic-antispasmodic effect. These components promptly control frequency and severity of any uncomplicated cough because they: soothe irritated respiratory mucosa, make cough more productive, relax bronchial spasm, and relieve congestive symptoms.

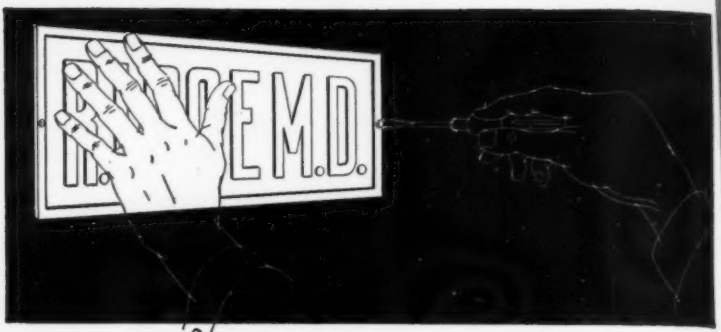
AMBENYL EXPECTORANT contains in each fluidounce:

Ambodryl hydrochloride (bromodiphenhydramine hydrochloride, Parke-Davis)	24 mg.
Benadryl hydrochloride (diphenhydramine hydrochloride, Parke-Davis)	56 mg.
Dihydrocodeinone bitartrate	¼ gr.
Ammonium chloride	8 gr.
Potassium guaiacolsulfonate	8 gr.
Menthol	q.s.
Alcohol	5%

Supplied in 16-ounce and 1-gallon bottles.

Dosage: Every three or four hours—adults, 1 to 2 teaspoonfuls; children, ½ to 1 teaspoonful.

PARKE, DAVIS & COMPANY
DETROIT 32, MICHIGAN



OPENING AN OFFICE

A. S. Aloe Company has a plan to help you

Since 1860 A. S. Aloe Company has helped three generations of physicians open their offices. Whether you plan to begin practice or re-equip an office, we can serve you.

A National Institution: We have 13 shipping points; more than 200 representatives with residences near you.

Equipment Check Lists. Cover everything required to outfit your office, from hypodermic needles to X-ray machines, with both itemized and total cost.

Planning Service. Suggested room layouts scaled to size to help you evaluate your needs.

Tailored Payment Plan. There are no interest charges under our regular "new office" extended payment plan.

Location Service. Aloe representatives know of many attractive locations for beginning practice. A statement of your preferences will be published to our field force. Write or see your local representative for details.

SINCE 1860

aloe

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KANSAS CITY DALLAS NEW ORLEANS ATLANTA MIAMI WASHINGTON, D. C.

intramuscular

VARIDASE*

Streptokinase-Streptodornase Lederle

provides

remarkable

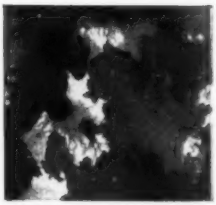
control

over

inflammation

Many patients with inflammatory lesions respond dramatically when VARIDASE is given intragluteally. Action is similar to VARIDASE applied locally, but results are much more swift and hitherto unattainable areas may be treated by the intramuscular route.

When employed in this manner, VARIDASE lyses the "limiting membrane" of leukocytes and fibrin which is thrown up about an inflamed or infected area. Thus, liquefaction and resorption of the contained exudate is made possible. In case infection is present, or feared, an antibiotic such as ACHROMYCIN* Tetracycline should be administered concomitantly to prevent the development of generalized sepsis.



Recent investigation has extended the list of indications for intramuscular VARIDASE therapy to include abscesses, burns, cellulitis, edema, epididymitis, hemarthrosis, sinusitis, lymphangitis, lymphadenitis, and thrombophlebitis with or without superimposed infection.

VARIDASE (Water Soluble—No Oil)

Administration: INTRAMUSCULAR, deep in the upper, outer quadrant of the buttock

Lederle

LEDERLE LABORATORIES DIVISION, AMERICAN CYANAMID COMPANY, PEARL RIVER, N.Y.

*REG. U. S. PAT. OFF.

a new maximum
in therapeutic
effectiveness

a new maximum
in protection
against
resistance

a new maximum
in safety and
toleration

for
your
entire

multi-spectrum
synergistically
strengthened...

Sigma

OLEANDOMYCIN TETRACYCLINE

patient
population






a new certainty

in antibiotic therapy,
particularly for
the 90% of patients
treated at home
and in the office

Superior control of infectious diseases through superior control of the changing microbial population is now available in a new formulation of tetracycline, outstanding broad-spectrum antibiotic, with oleandomycin, new Pfizer-discovered antimicrobial agent which controls resistant strains. The synergistic combination now brings to antibiotic therapy: (1) a new fuller antimicrobial spectrum which includes even "resistant" staphylococci; (2) new superior protection against emergence of new resistant strains; (3) new superior safety and toleration.

mycin*

*TRADEMARK

Pfizer

Concluded from page 20

ping the Ob-Gyn Office." I would very much appreciate your sending me a copy of that issue, or a reprint of that article. I will be glad to pay any appropriate charges. And other pertinent articles would also be appreciated, especially if there has been one on the subject of "Partnerships," or "Planning and Building An Office," especially if pertaining to Ob-Gyn. (I have your recent issues on "Buying Your Office Equipment" and "The Question of Fees in the Beginning Practice.")

Thank you very much for your courtesy and service. I might add that your publication is at the top of the periodicals I read regularly.

Talbot F. Parker, Jr., M.D.
North Carolina Memorial Hospital
Chapel Hill, N. C.

Dayton Data

In Volume 2, Number 10 of RESIDENT PHYSICIAN, your otherwise excellent article concerning the Veterans Administration stated that Dayton VA Hospital had 397 beds.

This hospital has, in fact, 1013 operating hospital beds available for residency training in all the specialties you mentioned plus radiology. Approval in radiology is presently for one year and conversion to three year approval is now under consideration by the appropriate residency review committee. Since the number of residencies far exceeds the available number of residents, we would appreciate a correction of this statement in an early issue.

Thank you for your courtesy in sending us your journal regularly.

A. Tomasulo, M.D.
Director
Professional Services
Veterans Administration Center
4100 West Third Street
Dayton, Ohio

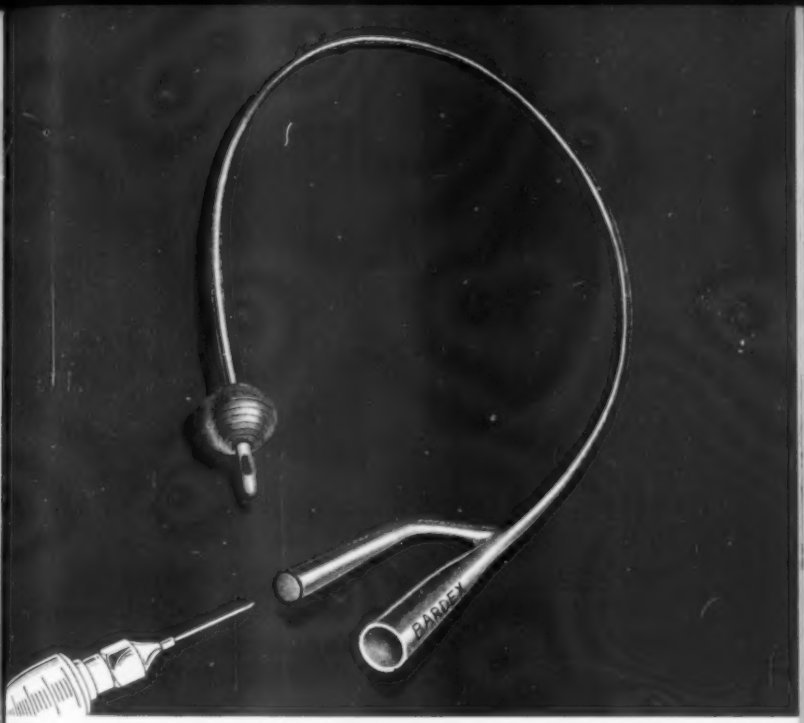
VA Report

The listing of the approved residency programs available at Veterans Administration Hospitals in the October 1956 issue of RESIDENT PHYSICIAN is highly commendable.

The pathology residency program at the Los Angeles Veterans Administration Hospital has recently been accredited for *four* years instead of *three* years as designated on page 81 of your journal. Under this program, the resident qualifies for certification in both Anatomical and Clinical Pathology after spending two years in each of these disciplines.

A correction from the listed three year to the actual four year approval in a future issue of RP would be deeply appreciated.

B. G. Fishkin, M.D.
Acting Chief
Laboratory Service
Veterans Administration Center
Los Angeles 25, California



SAVE Time by Using This Gilbert Type BARDEX® FOLEY CATHETER with Self-Sealing Plug in Inflation Funnel

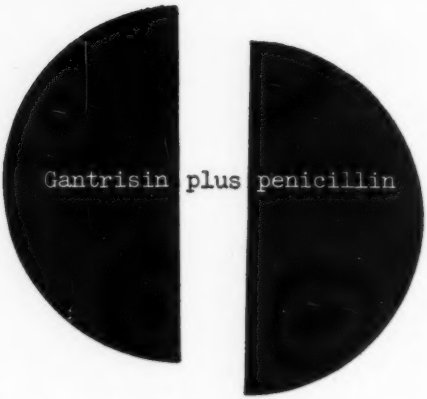
ONE PERSON can easily inflate and deflate this Gilbert type BARDEX Foley Catheter. No assistant is needed to clamp or tie off the inflation funnel.

Using a syringe with a 1 inch 20 gauge needle, the plug is easily punctured. Then the balloon is inflated to the exact size desired with a measured amount of water.

When the needle is withdrawn, the plug is self-sealing. There is no drip after inflation or deflation. To deflate, merely puncture plug with needle on empty syringe.

More and more hospitals and physicians are saving time and money by using this Gilbert Type BARDEX Foley Catheter.

C. R. BARD, INC.
SUMMIT, NEW JERSEY



Gantricillin is Gantrisin plus penicillin in a single tablet. For severe infections, Gantricillin-300; for mild infections, Gantricillin (100); for pediatric infections, Gantricillin (acetyl)-200 suspension.

Gantricillin® Gantrisin® - brand of sulfisoxazole

roche

original research in medicine and chemistry

Perrin H. Long, M.D.

Editor's Page

Pharmaceutical Advertising and Promotional Literature

RESIDENTS AND INTERNS at times receive letters, brochures, circulars and other literature from various components of the pharmaceutical industry. As the resident establishes himself in practice, the quantity of such mail will increase substantially. And although the intent and value of this plethora of literature is frequently questioned by doctors, a number of physicians who have devoted considerable thought and study to the subject of medical advertising are convinced that the literature made available to physicians by the pharmaceutical industry represents one of the major factors in the postgraduate education of the American physician.

"If this is the case," one may ask, "how well is the job being done? How thorough is this 'education by literature'?" Perhaps most significant to the answer is the fact that pharmaceutical product information is based primarily on the pharmacological, toxicological and clinical acumen of our scientists and technicians. We can presume, therefore, that the information stems from reliable source material.

When an occasion arises which leads us to question the information presented, it is usually because one of our community of physicians has been overenthusiastic, uncritical or has misinterpreted his results. Certainly, in these instances we cannot hold the pharmaceutical industry wholly responsible.

The pharmaceutical companies do have an obligation to check the statistical accuracy of clinical studies under their direct sponsorship, and further, to select the physician-directors of such studies from the ranks of investigators whose integrity is unquestioned.

But the industry does not sit in judgment on members of our profession. In the last analysis it is through the exercise of each physician's own critical faculties that all medical literature must be evaluated. As physicians, we are the final judges of the competency of our colleagues.

The pace of pharmaceutical research has increased at an amazing rate over the past decade. And despite the many criticisms leveled at pharmaceutical literature, physicians have come to depend to an increasing degree on pharmaceutical advertising and promotion for capsule information concerning new products.

In this, medical journal advertising plays an important role. Most medical journals could not exist, except at very considerable increases in their cost to the physician, without the support of advertising created and paid for by the pharmaceutical industry. (Obviously, this support of journals would not exist to any important extent if the pharmaceutical companies weren't convinced of the fact that physicians read advertising material published in medical journals.) And the main reason the physician devotes the time to digest information presented in the advertising is so that he can keep up-to-date on the latest developments in pharmaceutical products, quickly orient himself on indications for the use of new and old products, and read in abstract much of what is coming to his desk in the form of promotional mail.

Perrin H. Long.

I'm the Private Patient In Your Future

Here's a point of view that may help your perspective, a composite picture of "the patient" in your practice, a two-headed monster and a halo — with fee attached.

Dan Anderson

Sooner than you may realize, you'll finish that residency. Then—wham! —you'll meet me. All-important me! Puzzling, puzzled, arrogant, docile, independent, obedient, changeable, constant, fearful, courageous, mixed-up, canny me.

Who am I?

Your private patient!

Necessary me, too. I'm obviously necessary to you. You're definitely necessary to me. How do we get together, and stay together? I'm writing this in hopes of helping us. It's to tell you what I'll expect and demand of you. It's to tell you what you may look forward to from me.

Available

First of all, Doc, remember I'm not provided to you, like the patients you're seeing now as a resident. I can go somewhere else besides your office. Or I can see you once and choose not to come back. It's up to you to get me there the first time and to make me want to return whenever I need your help.

Getting me in at first is pretty much a matter of choosing your

---

About the Author—Dan Anderson, a free lance writer, reports he was eager to handle this assignment. "I'm just grabbing a chance to do the prescribing for a change . . ." Mr. Anderson began his newspaper career on the Moline (Ill.) Dispatch, put in 22 years on the New York Sun covering science and medical news, and had a three-year stint as editorial writer on the San Diego Evening Tribune before holing up in Chapel Hill, N. C. from whence he penned this many-sided opus on the whims and fancies of patients.

spot, hanging out your shingle, waiting and, in a specialty, letting other physicians in those parts know you're available. (This is no cinch, but it's outside the scope of this piece.)

Making me want to return is a big, new task you must tackle.

You'll have to humor me, of course, put up with some ways of mine that seem odd and trying. Just for a sample: I wonder if you gritted your teeth a bit when I called you "Doc" at the start of this opus? You're properly proud of the whole title, "Doctor," and having it chopped short may grate. But face it, I'm still going to call you "Doc" sometimes, so learn to take it.

This doesn't mean I'm trying to whittle away your dignity. I expect you to be dignified, but with inner, essential dignity, not the kind that sets big store by titles and trappings. Dignified, yes! Pompous, no! Chest out, but not encased in a stuffed shirt. Head high, but not nose in air. Just you be a skilled physician; be a strong support to the weakness that brings me to you, and my thoughts will clothe you with all the real dignity you could desire—even though I may stick to my habit of calling you "Doc."

Figure me out

Of course, I might occasionally be a cringing neurotic who wants medical commands as from on high. I'll put you on a throne. Or, I may resent your superior knowledge and tear you down. I'm the most varied critter you ever met. A fretful mother, a stoic elder, a shy adolescent girl, an adolescent boy, even shyer; a desperately ailing man who doesn't want to acknowledge the fact, an unfulfilled woman who craves a physiological explanation for her trouble of spirit (with your help needed just the same)—or a thousand and one persons more. You'll have to figure me out each

time, and handle me accordingly. You see you'll be able to count on one thing. I'll be different from all others. I'll be me.

Of course, you've already experienced the never ending dissimilarities among various patients. I hammer at it, though, simply because it will take on so much importance when you start private practice.

Business principles

Here are two other facts, doctor. When you enter practice on your own, you go into business. Don't get me wrong. I'm not saying that you ditch your Hippocratic Oath and turn to dollar-grabbing. Rather, you must add sound business principles to your science and humanitarianism. This may come to you as one of the two big shocks to jolt you when you get out on your own.

The other, which many doctors call the hardest, is all of a sudden finding yourself without supervision, without many senior colleagues to fall back on and consult when you're the least bit baffled. It's rough on specialists. According to your patient, you are supposed to know everything in your field — as though anyone ever could know it all.

More about you in business. I'm very big about it and grant you a right to a living, even a good one; though I may force you to work like a whole beaver tribe to earn it.

So, figure your costs. These won't be merely the routine daily expenses. You'll be smart to add in enough to gradually make up for the time and cash you've invested in all your training. Allow, too, for an excess fund to permit you and your family to lead an easier life in days to come. Work out the sum, take note of what other specialists in the vicinity charge, fix your fee, and send me your bill.

I'll pay — more often, more gladly than some dismal tales of disregarded doctor bills suggest. If I grumble once in a while, I do the same about the milk bill, too. But, a businesslike transaction is respected. So be businesslike.

Money will have become an essential part of our entire proceedings, to be mentioned and taken into account along with the rest. It's far from the cream of our relationship, but it's there — homogenized in, you might say. I'm making this point strongly because this may be a new aspect of medicine to you.

Estimate

Do your best to let me know what I'm finally going to have to pay. If I run a store, I price my goods plainly; you can come close to that by giving an estimate, revising it from time to time. Try to avoid the unpleasant moment when I come to you and say, "Gosh, Doc, I had no idea your bill would be that much!"

Also, get an idea of what I can afford. If it's not a great deal, spare me lab fees and the like unless they're absolutely essential. In training, you often order tricky work by technicians for the sake of showing you what's behind quite definite symptoms.

But, in private practice, don't reconfirm a sound diagnosis needlessly —at my expense.

Also, if there's a toss-up between two courses of treatment, lean toward the less costly one. If one course is a trifle more advantageous, but will cost a whole lot more, talk it over with me fully. Ask what I'd like done.

Example

Even if you don't like the idea of being in business for your own sake, doctor, you'd have to be in it, for mine. Take the extreme example: If you were so financially sloppy that you ran behind in your rent and were evicted from your office, I wouldn't be able to find you when I needed treatment. The same idea goes for equipment and supplies to use for my benefit. You need quarters well fitted out, with a waiting room that soothes me before I consult you. Even so, I may be nervous, have to go—and the electric company won't fail to send you a bill for the light in the john.

You're going to be in business on a broader scale than just taking in cash. A shopkeeper calls me his customer. And you'll call me your patient. Both of you want me to come to you to get something of value. You can offer an immense value. If I don't come and get it, I'm the one who's worse off; but all your training and knowledge will go to waste. So don't be ashamed or sorry or hesitant about being in business.

Your income is earned and deserved by providing me with the science of medicine and the art of making it easy and pleasant for me to take.

Recommendation

You can't, it's true, use the devices a shop does to attract my attention. Your code of ethics forbids anything that smacks of advertising. (I respect the code, but its strictness sometimes puzzles me.) So your best method is to treat me right — "treat" in a larger than merely medical sense. I'll stick with you. Because I don't fully understand why your feats don't rate half a page in the town paper, I will want to make up for this lack. I may make a special point of telling my friends how good I think you are. Then you'll have the unbuyable, best advertising any firm or person can enjoy—word-of-mouth recommendation. You'll win a lot more than advertising. You'll build a reputation. Turn me into a pleased patient, and watch more roll up to your door.

Back we come to the doctor-patient relationship, which really is

more than that, a person-person relationship.

Hyper

And here's the important bit: Every time I come to you or call you, I'm afraid I'm going to die.

The fear may lurk so far in the back of my mind that I don't actually recognize it. I may, out of either courage or cowardice, suppress the recognition. It's still there, however far in the mental shadows.

Perhaps I have no more than an extra-sore hangnail. Yet, I can without strain conjure up a train of visions of spreading infection, gangrene, vain amputations, pall-bearers!

You won't encourage this fear; only a quack would do that. A lot of your task is to calm it. But you should take it into account. It can explain much odd behavior of mine; for example, why I'm so often hyper in your presence—hyper-chatty or hyper-stolid or almost any brand of hyper.

There's nothing more important to me than my health and my life, and they're my reason for seeing you. This fills our contacts with intensity. If you seem to give a quick brushoff to the engrossing subject of my health, I rate you as cold as a polar iceberg, and no more pleasant to visit.

Reassure

Remember, I'm hypersensitive in this situation. Give me even a hint that you look on me as some sort of symptom-bearing bush, cast a glance that suggests you're looking at me like a page in a medical text, glaze your expression as though I were telling a dull, old tale, and I'll be

rebuffed and sore where no salve will help. I'm not asking that, if I display a wart, you turn verbal somersaults and exclaim that you never in all your days saw anyone with such a wart. You may do well to assure me by saying you've seen that type of wart before, and the folks with it did fine.

But don't belittle my wart too much. Rather—and here's a distinction that may seem fine but is vastly important—don't belittle me, with my wart, at all. Here and now I have a wart and I am presently, personally bothered by it. Respect

my feelings about that wart. It may be trivial, but what I think about it isn't. It's the reason for our encounter, and that alone gives it importance.

And say, Doc, never let yourself speak or so much as think of me as "the wart." If ever I hear you describe me or any patient as "the appendectomy," "the Potts fracture," "the Gleepus-Schmeepus syndrome" or by the name of any medical condition, I'll take it miles amiss. I'm at least "the patient with the wart." In full truth, I'm the person with the wart who has asked you for help with it.

Think of me in such completeness and put your feeling across to me, and when I say "Doc" it will be a heart-warming word.

Devious approach

Also, pay attention to more than the wart and you may make surprising discoveries. I'm frequently devious in my approach. Give me a chance, and I may go on to reveal a deep trouble, far different from the wart, far more serious, far more worth your attention from both our standpoints.

Your present advisers keep yakking about the need for full histories. They're so right, even if repetitious! And when I say in your private office, "Doc, I've got a wart," you're just starting to take a history—without so much as a hint of a diagnosis from a referring physician, maybe; with no med student to do the scut work or the preliminary physical, with no senior to check up on what you might omit. You must do the whole job and make it good. Bear in mind that when I tell you my presenting complaint, I'm sometimes doing little more than sort of saying, "Hello."

It might reward you, doctor, in preparation for meeting and treating me, to track down a psychiatrist (assuming you're in another field), even though he's as hard to corner as that recent symposium in RESIDENT PHYSICIAN suggested. Give a little attention to transference, that invisible but provable bond between patient and physician. In its positive form, the transference fills the patient with trust in his doctor, may increase the beneficial effect of medication and of any therapy he orders. Yes, you'll be working with transference, so you might as well know about it.

Good medicine

Plant it in your mind how much the patient's ideas about the physician mean to the outcome of treatment that might be considered almost mechanical. (You, of course, realize that there's also a negative transference, which could make me discount you and all you do and direct.)

Get a hint of counter-transference, how the doctor feels about the patient and what effect that has. (Ask the psychiatrist if it isn't a fact that the more trust one of his

colleagues has in electroshock therapy, the more effect it seems to have on patients whom he "buzzes.")

Building a positive transference was what successful oldsters did who cultivated a winning "beside manner." It wasn't mere acting or hypocrisy. It was good medicine. It still is.

Ours is a human relationship, doctor, full of emotion (on my part at any rate), including that fear of death I mentioned. You bring science to it, but you'll have little more success ramming pure, cold science down my gullet than you would have trying to swab my throat without first saying, "Open your mouth, please." By and large, I take your technical skill and your technical knowledge for granted. I have to. I have no way to check on them. What I can understand and enjoy or dislike is the way you behave toward me while you're applying them. I'm also interested in results, certainly, but remember you'll certainly agree that the nature of my transference to you, based on the personality I see, can have a strong effect on results.

Don't rush

Give me plenty of time or, anyway, act as though you were doing so. There are ways to put the impression across. Take ten minutes with me, and drop in a casual, extraneous remark, like saying you saw the zinnias in my yard the other day and they look fine. I'll feel that it's been longer than ten minutes. This rule will have to be broken if I'm a forever-talker. But even if I am, seek some gracious way to cut my gabbing short.

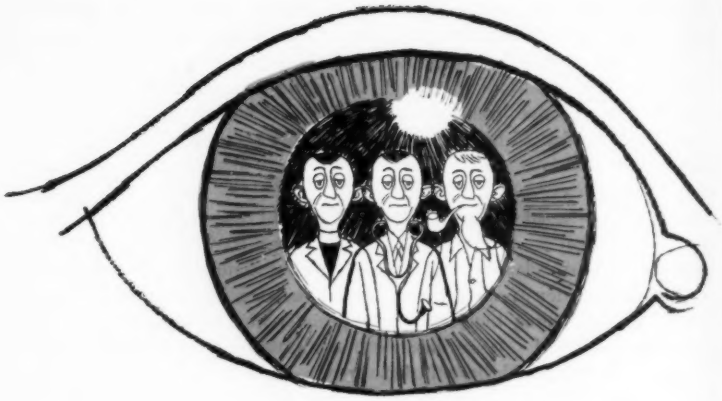
Punctual

You still shouldn't take up my time unnecessarily. I won't relish sitting for hours, or even for too many minutes, in your waiting room, especially when it simply allows me time to think up new reasons for dread.

Try, too, to keep a *dependable* house-call schedule. Arrive close to when you say you will, and don't set times you're unlikely to meet. Give yourself leeway for the unexpected, but remember that on the dot is best, early is fine, late distressing. My condition is central to me. I understand I must share your attention, but I appreciate it immensely when a period is set and kept for focussing your attention solely, undividedly on me.

Health

Now, what do you know about health? This isn't a catch question, though it has caught a lot of beginning practitioners. You've been dealing with illness, learning about illness, just about living with illness. Can you have lost sight of health? It's the goal you and I seek together. Could you fail to see the health forest, from so much looking at the twisted trees of illness? It's



a real risk in your profession, especially in the concentrated training time. Yet your aim and my wish are the same—perpetuation and restoration of my health. You'd be wise, then, to carry a clear picture of it in mind: a decently normal, satisfactory state of health.

No rarities

As student, intern and resident, you've been seeing extreme cases. You've seen them terminal, you've seen them exacerbated, you've seen them practically monstrous. Such dillies are likely to be rarities in your practice simply because of the way the general population differs from a hospital population. When one turns up, you'll in all likelihood hustle it to a hospital, because it needs the facilities of such a place. While a new crop of residents watches it there, you'll be seeing a lot of mild forms of whatever it is, that your field covers.

You'll see suspected cases that aren't whatever-it-is, at all. You'll make me mighty happy, too, if I'm one of these, and hear the glad words, "No, you don't have the galloping glanders, but just a slight gadzooks that ought to clear up in about a week."

Time after time, you'll see me only a smidgen removed from the best health I'll ever possess. You'll need only to nudge me gently back to my optimum state. You ought to know health, Doc, so you can deliver it—your greatest stock in trade.

Don't think, either, that ridding me of that wart is less important in its fashion than hiking out my colon, vacuum-cleaning it and putting it back with new brackets, or whatever your ultimate accomplishment may be. (That may not be

just what you do, but I've admitted my ignorance of medical terms already.) As to the wart, though, if it's all that's wrong with me, and you relieve me of it, you make me healthy, and that's what I ask. To you it was only a trifle, but you were successful with it, and success is never a trifle.

A little learning . . .

Speaking of my ignorance, doctor, never underestimate it in your special field. (You needn't take me for an all-round fool, either, unless I prove it abundantly.) Realize that I'm not learned in medicine and its terms, but assume I have common sense. In fact, you'd better be exceedingly wary whenever I display some smattering of physicianly lore. This could mean I'm a hypochondriac, and then obviously I've gathered a jackdaw's nest full of medical terms and stayed blind to the truth back of them.

It may mean I've just finished reading the latest popular medical article in a newspaper or magazine, gleaning dabs of data with no guarantee of full understanding. For a current example, if regional ileitis came into the conversation, I might say I wondered whether a bypassing operation was best for it. This would mean simply that the subject has been much in the news recently, by no means that I'm an authority on abdominal surgery.

I advise you always to take my bandying of technical terms of medicine as a danger signal. If you let yourself be fooled into considering me anything like fully informed, you'll pass over great gaps in my knowledge. The way popularizers of science pour out writing nowadays, almost any literate person is likely to have read that Myomycin may help some obscure balinese fever—and still think that five grains of aspirin would mean five of the standard tablets. Always consider my little learning a dangerous thing.

Analogies

Talking to me about my health, go step by step, use commonplace illustrations and analogies as much as you can, remember I'm likely to be in a bit of a tizzy, quick to misinterpret for good or for ill. Ask occasional questions to make sure that I'm really getting into my head what you want to put there.

No dire warnings

What are you after? To make me cut down on eating fats? Remind me how much trouble grease poured into the sink can cause, and point out that I'm full of pipes. That may be enough. Leave out all fascinating (to you) minor but irrelevant details. They might fascinate me, with unfortunate effects. Follow the line recommended in telling children about the facts of life, and stop when the question at hand has been answered. Too often, if my minor ache reminds you of a

distant, dire disease cousin, and you discuss it in your over enthusiasm, I may suddenly think I've developed it. Then you'll have to waste time and trouble for both of us, convincing me I've got no such thing.

Anxiety speaks

I hope you've noticed, doctor, that I've refrained from telling you how to practice medicine—what pills or shots to give, that is, whether to use silk or catgut sutures, and all such. I said I took your skill and learning for granted. Almost all the time I do. It's particularly easy now, when I feel well and calm. But sometimes I get a pain—go in to see you — and start to prescribe what you're to prescribe. Please excuse me. I don't mean to reflect on your ability and judgment, but I'm upset and anxious.

Perhaps I've just read another article about the marvels of Myomycin, or a pal had a sharp pain in his somewhere, and his doctor gave him a slug of Myomycin, and he didn't die, after all. So I romp into your office and tell you that you ought to give me Myomycin. (If you told me that I should have started that last sentence, "So into your office I romp &c., &c., I'd be quick to suggest that you let me do the writing around here, and you practice medicine. I just don't realize that I'm doing the same sort of thing to you.) It's my health that's concerned, and my perspective is all out of kilter.

You know best

Deal with me gently, Doc, but firmly. Stick to what you think is best because, after all, you do know best. Point out that my complaint isn't a rare Balinese fever. Remind me that the same twinge went away once before without fancy, costly shots. Perhaps you could tell me that it should yield again to the previously successful treatment. Announce that it's your considered judgment that Myomycin isn't the stuff for me at this time. And give me none of it. I'll admire and respect you for that.

In about a month, I may be proclaiming, "Doc could have given me that newfangled Myomycin that's so doggone expensive, but he knew an easier, better way to cure me. He's one fine doctor, he is!"

Shopper

If I'm a medical shopper and drifter, I might make your unwillingness to shoot me full of Myomycin an excuse to leave you. Call it good riddance. Sometimes I'm like that, and then I'm a thoroughly unsatisfactory patient, and never satisfied with you. Let me go, without regret. A certain number of patients will quit you cold for no good reason you can see, probably because it doesn't exist. If you're doing your best, you're better off without such patients.

As I write, you're a resident, qualifying for a specialty certificate, and I've been discussing my "wart."

Warts may be entirely outside your chosen field. (I hope you have realized I meant "wart" as a symbol, and have read the right substitute word into places where "wart" appeared.)

But I hope you won't let your specialty put you in such a straightjacket that you'll disregard a wart, neglect to notice your patient has one, even if it's not strictly a subject for you, get to thinking that a wart or anything else outside your specialty doesn't matter a bit. While your own topic is important to you, it's my health that's important to me. Without asking you to engage in general practice, I do ask you always to take a general, broad view of me. Emphasis on your specialty mustn't mean elimination of all other interest.

Public relations

Let's say you're a pediatrician and I, aged fifty plus, come into your office with a sore toe. I've seen your shingle with "M.D." after your name, and my foot hurts, and I want help. Don't mount a high horse and say, in effect, "Sirrah! I am a pediatrician, limiting my practice to the treatment of infants and children, and how dare you suggest I should attend you?"

I may not quite know what a pediatrician is, but I know you're a doctor, and I most excruciatingly know that my toe pains me. I'm someone in trouble, and you mustn't reject that appeal.

You can explain that you're not just the doctor for me. Say you treat only children, and perhaps you'd be a bit rusty with an elder patient. Be sure to tell me you're sorry my toe hurts, and look at it if you can spare time.

If first aid is needed, give it. Then suggest another doctor, or more than one, who you think could do what's necessary. You'll have done a kind, considerate act.

There's no knowing but what a few days later I'll come back, limping a little, with my six grandchildren to have them checked up. That would be good business for you, and just making the good impression would be good business for your whole profession.

Impression

For, though you're in practice by yourself, you're a representative of all doctors. I'm too much given to categorizing, and much to much to lumping all physicians into a class that behaves like the few I've met, or the last one I've encountered. "Doctors, they're no good!" I'll explain, or, "Doctors, they're grand people!" It will really mean that I just saw a doctor I didn't like, or one I did. You may be that one, doctor, so for the sake of the AMA plus, strive to impress me well.

Appearances

So far, I've discussed your behavior while you were practicing your profession. Doc, whether you

like it or not, there's more to come. Brace yourself.

You'll find I've put you on a pedestal. Not way up there, but up. Exalted position has its gratifications, but a high perch frequently proves less than entirely comfortable. Not only do I watch you in your office, but outside, too. That can be a bother.

I expect you to keep up appearances, but not gaudily. When, for instance, you buy your next automobile, you'd better think of suiting me as well as pleasing yourself. I think you deserve a good car, surely one that will bring you promptly to my home if I call. But I'll look resentfully at you in one of the most expensive makes. I'll also probably consider a sporty, snazzy, little imported roadster out of keeping with the lofty status of a physician. Silly of me? Granted. But true, all the same.

Conservative

The rule holds concerning your house, your clothes, your possessions of all sorts, and those of your family. Let them be on the conservative side. If some day you begin to subscribe to it, let the Wall Street Journal stay out of my sight. I'd rather think of you poring over the Annals of Whateverology than studying the stock tables.

If you do anything that flaunts signs of superhigh prosperity, I begin to begrudge it. A feeling hits me that I had to have a pain so you could own a bond, and this grates on me. I'm not against your having valuable belongings, but I dislike a dazzling display of them. In part, I may envy anybody else's good fortune, but with you I particularly don't like to be reminded of it and, in the same instant, of the bad luck that strikes me when I fall ill.

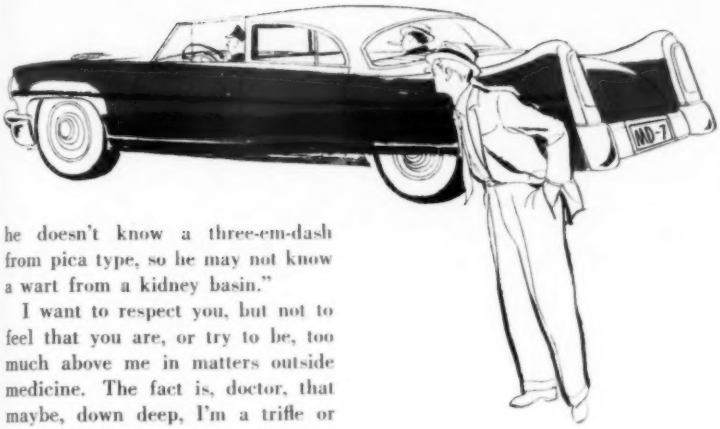
Never, doctor, let me see you even a trifle tipsy. I want to think of you as ever ready to handle a call. Avoid letting me see you dirty or disheveled, unless there's a good reason such as working in the garden or playing tennis. You don't have to look scrubbed for surgery all the time, but I'd sort of like you to come fairly close to it.

Silly? Sure it is. But it's a common form of silliness and is not to be laughed off.

Take a middle course, Doctor, in public and social contacts. You shouldn't play tournament bridge lest I fear you've slighted your science to study the Vienna coup. You shouldn't play too badly, either, for I don't want you to seem like a dumbell in any regard.

Give your opinions about topics outside medicine modestly.

I may attach too much weight to what you say, because you're a doctor. You are on that pedestal. Or worse, I may be expert on some subject about which you sound off, and catch you in a serious error. Then, unreasonably but almost inevitably, I'll say to myself, "Why,



he doesn't know a three-em-dash from pica type, so he may not know a wart from a kidney basin."

I want to respect you, but not to feel that you are, or try to be, too much above me in matters outside medicine. The fact is, doctor, that maybe, down deep, I'm a trifle or more jealous of you. I submerge this envy when I see you professionally, but its topknot may bob up when we're doing something else.

Health talk

At parties, I'm bound to bring the talk around to medicine. Again, my health means a lot to me, and there's a sort of equation in my head: Health equals interest and doctor equals health and, since things that are equal to the same thing are equal to one another, a doctor must be interested in health talk.

Your best defense is to find something else that interests me, and inject that into the talk. That way, you may learn plenty about hi-fi or whatever my specialty may be, and perhaps you'll divert me from making you talk shop. Perhaps.

My scrutiny of all your life may be irksome, and my equating you with a single subject may be a bore. School teachers and clergymen have to put up with the same sort of thing (though it's odd that lawyers don't get so much of this kind of treatment). At least, you have company in the situation, and it's proof that I hold you in special esteem. It's a compliment, even though sometimes I cause the head that wears an M.D. crown to lie uneasy.

Riches, surprises

You're coming out of the cloisters, doctor, into my world that will welcome you, stand ready to laud and reward you, but at times will shove you around. You're in for surprises, good and bad. You may find among your fellow physicians, with whom you'll have to balance relations delicately, an occasional example of a

complete heel. To make up for that, the chap who installs your telephone may be a grand guy. Study them both for tips on what not to be and what to be, what not to do and what to do.

In your future are vexations and unpredictable problems, but also the prospect of a rich life in far more than the financial sense. Waiting for you are true dignity and respect, gratitude and glimpses of faces you'll know you have made rosier and turned smiling.

You've been hard at it, learning your medicine. I hope this piece has hinted at what you must discover about me—your private patient. You need me, doctor, and I need you greatly. I hope we can have a long, mutually enjoyable future together.

"In this case, the membranocartilaginous epiphysis in the left knee is being aggravated by early stages of periosteoma, complicated by phlebomyomatosis of the leg, Mrs. . . . er . . . I've forgotten your name."

John G. Mateer, M.D.

Guest Editorial

Preventive Medicine—Why and What?

TO THE UNDERGRADUATE medical student, the term "Preventive Medicine" often has a hollow ring. His main interest frequently consists of learning all he can about the gross and microscopic anatomical findings and the clinical characteristics of various disease processes. To the thoughtful, conscientious and forward looking practicing physician, however, preventive medicine, with its various ramifications, presents a tremendous *challenge*, which to date has not been emphasized as much as it is bound to be in the immediate future.

The increasing medical knowledge of the public is resulting in a request for more instruction and protection. Patients are profoundly appreciative of information about the prevention or early detection of physical disorders. The practical dividends to the patient are much greater from this approach than from that of concentrating on the diagnosis and often ineffective efforts in treating fully developed disease. Patients are interested in the diagnostic evaluation of their condition mainly because they hope that this preliminary effort will lead either to prevention of disease or to its early detection and correction. The fact that a patient has no symptoms or signs does not mean that a condition urgently in need of medical evaluation is not present.

What are the important aspects of preventive medicine about which the young physician should be thinking during his resident period of training? In the first place, he should appreciate the well established observation or fact that there are different degrees or levels of health. For example, there is a striking and obvious contrast between the health

JOHN G. MATEER
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level of the tired, nervously tense, middle-aged business man without demonstrable organic disease but with an array of uncorrected faulty habits, and a similar individual who has decided to follow his doctor's advice, has corrected these habits and profited from a month of complete rest and out-of-door vacation. Patients should be challenged to attain and maintain as high a health level as possible.

Secondly, much more emphasis should be placed upon the detection and correction of early pathological physiology by conducting the now available and *highly sensitive* function tests of various organs. In the future, undoubtedly additional highly sensitive function tests will be developed which will enhance still further the opportunity to detect early functional impairment. However, positive results from tests now available afford *objective* evidence of early abnormal function, often before anatomical disease has developed. Such concrete evidence will sometimes induce a reluctant patient to eliminate the contributing etiological factors when the physician's persuasive powers otherwise may fail. The functional deviation may be corrected then, before anatomical pathology has developed.

In the third place, patients now frequently request so-called "annual health checks." These studies, in the absence of any symptoms or positive physical findings, may disclose serious, *early organic* pathology. Early pre-clinical diagnosis and subsequent therapy can either eliminate or usually curtail the progress of the disease. Studies of this kind should be comprehensive enough to reasonably eliminate any type of early pathology present.

One further point: The fact that the ultimate or final etiology of many disease processes is unknown should not discourage the physician from using an *etiological approach* to therapy or to the elimination of the *probable contributing* factors.

In order to plan the program of treatment designed to raise the individual's health level, to correct demonstrated pathological physiology or to discourage the progress of early pathological anatomy, one should determine as far as possible *all* probable contributing factors and then attempt to persuade the patient to eliminate all of them. In fact, this is the main secret to successful therapy in a high percentage of patients.

Number fourteen of a series from leading medical centers

Clinico-Pathological Conference

Henry Ford Hospital, Detroit, Michigan

Present illness

A 64-year-old Italian male factory worker was brought to the hospital against his wishes by a friend. The patient was aggressive, belligerent, and gave only a fragmentary history. He claimed he had enjoyed good health until about six months earlier when he had become aware of occasional nondescript epigastric distress attended by unusually loose stools varying from orange to white. For three months he had noted progressive swelling in his abdomen and ankles with itching in the lower legs. Within six weeks of his admission, his weight had dropped from 235 pounds to 193 pounds.

It was learned that the patient had subsisted on a diet made up principally of spaghetti and obviously deficient in protein for many years. Over a similar period it had been the patient's custom to imbibe a gallon of wine and one-half case of beer each day. However, during the month prior to entry he had almost abstained from food or fluid of any variety. He denied hematemesis and had not observed melena.

Physical examination

All vital signs were well within normal limits including the blood pressure of 110/70. The sclerae were faintly icteric. Except for elevation and relative immobility of both hemidiaphragms, no remarkable signs were elicited in the chest. The abdomen was symmetrically distended, and shifting dullness was easily demonstrated. A firm liver edge was palpated with difficulty eight cm. below the right costal margin; the spleen could not be felt. Tortuous, distended superficial veins were seen in the skin overlying the abdomen but no telangiectases were found. Marked edema was seen from the feet to the buttocks and,

to a lesser degree, in the hands. There were superficial linear tears in the skin of the legs.

Laboratory data

Urinalysis was unremarkable. The hemogram included an RBC of 4.05 million, hemoglobin of 12.9 Gm., and WBC of 8150. Macrocytic red cells were evident in a smear of peripheral blood. The differential count of leukocytes was within a normal range.

Bile was present in the feces. The concentration of serum bilirubin was 4.0 mg. per 100 ml., (2.0 mg. "direct"); serum alkaline phosphatase, 5.2 Bodansky units; serum albumin, 2.9 Gm., and serum globulin, 2.6 Gm. The prothrombin time was 70 percent of normal.

The cephalin flocculation was four plus, thymol flocculation negative, and thymol turbidity, two units.

Aspirated ascitic fluid contained 1.44 Gm. of protein in 100 ml.; the specific gravity was 1.008.

Hospital course

Treatment included bed rest, high protein diet supplemented by the usual adjuncts, and mercurial diuretics; to none of these was there appreciable response. The patient gradually became more agitated, confused, and finally stuporous. One week after admission three liters of ascitic fluid were withdrawn; three weeks later six liters were removed. Six days following the second paracentesis, the patient lapsed into coma. Distinct fetor hepaticus was evident. Thereupon pulmonary edema supervened and, despite vigorous supportive therapy, the patient died on 42nd hospital day.

Dr. William S. Haubrich, associate physician, Division of Gastroenterology: If there is anyone in this audience who has read this protocol and believes the patient to have had other than cirrhosis, he is invited to make his claim now.

Audience: (no comment).

Dr. Haubrich: There is a remarkable background of nutritional deficit abetted by an almost phenomenal record of imbibition. A moment ago one of my colleagues suggested the man may have drowned. In any case, this patient's liver sustained a protracted insult to which its reaction must have been a marked fatty metamorphosis and subsequent advanced cirrhosis. My task is to decide whether there existed a disease in addition to, or rather than cirrhosis.

Intrahepatic block

Epigastric distress is fleetingly mentioned; I presume no more detailed history of its characteristics was elicited. While cirrhosis is often painless, a sense of fullness or distress, if not pain, in the upper addomen commonly reflects stretching of Glisson's capsule. The disturbance in bowel habit neither helps nor surprises me. The observation of white stools, which I take to have been inconstant, indicates an inter-

mittent, at least partial obstruction somewhere along the biliary system. Such *intra*hepatic obstruction is compatible with cirrhosis.

Obviously, the man had ascites; indeed, he had anasarca. I will assume that the itching of the legs was due to stretching of the skin overlying the edematous extremities rather than to jaundice. It is disappointing that characteristic "spider" telangiectases were not seen; they commonly attend an advanced cirrhosis. The relatively rapid loss of 40 pounds, in the face of mounting ascites and edema, is striking. Although the flesh of the advanced cirrhotic melts away (particularly noticeable in the extremities, shoulder girdle and chest), the fluid retention counterbalances, and there may be little change in gross weight.

Enlarged liver

From the physical findings we can reasonably exclude congestive cardiac failure by the absence of distended neck veins, rales, or any sign of heart disease. I may interject that often this differential diagnosis is not so simple, but that it may be promptly and easily resolved at the bedside by determining venous pressure. The liver was enlarged, and I will predict there was also splenomegaly which could have been demonstrated were it not for the ascites. The distended abdominal veins doubtlessly were part of a collateral channel circumventing a portal hypertension.

No mention is made of the texture of the skin, hair distribution, or the size of the testes. The skin was probably fine and smooth, rather of a feminine type; hirsutism may have been scanty; and the gonads may have been *hypo*trophied.

Macrocytic cells

From the laboratory we learn that the urinalysis and hemogram were essentially unremarkable, except for the macrocytic red blood cells. In this hospital, our hematologists are astonishingly adept at finding the macrocytes of liver disease. In fact, they occasionally suggest liver disease in a patient before we clinicians are aware of it. The hyperbilirubinemia confirms the observation of jaundice; the partitioning of the so-called "direct" and "indirect" fractions, in this case, would not help me. The level of alkaline phosphatase activity is slightly elevated from the average normal range reported in our laboratory.

Serum protein

For the serum proteins, I would have preferred to find less albumin and more globulin. Elevation of serum globulin has been particularly constant in the cirrhotics we see. The depression of serum albumin in this case was insufficient to have been a major factor in the anasarca but doubtlessly made a contribution through its lessening of oncotic pressure.

The reaction among the several

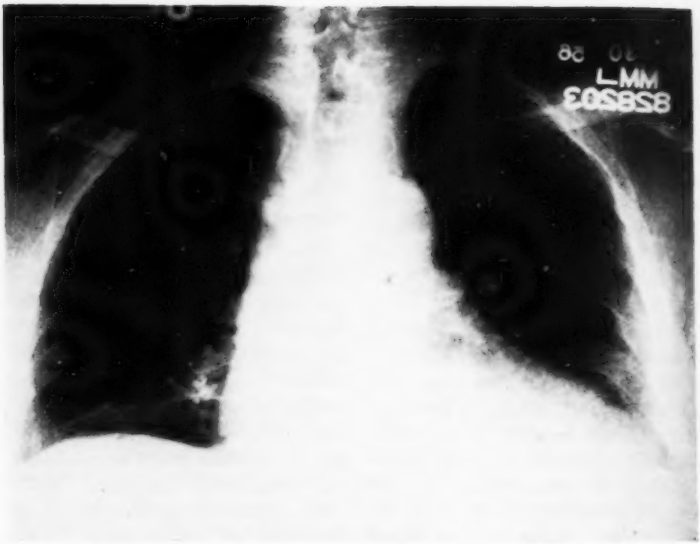


Fig. 1. Radiograph of the chest showing elevation of both hemidiaphragms and "Blunting" of the costophrenic sulci.

flocculation tests is inconsistent, but that is why we always ask for the battery rather than for one alone. Although the apparent degree of bromsulfalein retention may have been exaggerated slightly by the hyperbilirubinemia, the figure of 46 percent unmistakably indicates impaired liver function.

From its specific gravity, the fluid obtained by abdominal paracentesis was clearly a transudate as we would expect. We have learned that the protein concentration of ascitic fluid reflects, in general, the level of serum proteins. The usual concentration in cirrhosis is from 0.5 Gm. to 1.5 Gm. in 100 ml. In our patient the serum level was remarkably good; therefore, the protein content of the ascitic fluid was relatively high. Further, we know that this protein is not sequestered but is in dynamic equilibrium with the total protein of the body economy. If we estimate our patient contained 10 liters of ascitic fluid, this would include 144 Gm. of valuable protein. Hence, we are reluctant to withdraw such fluid except for diagnostic necessity or mechanical relief of pressure.

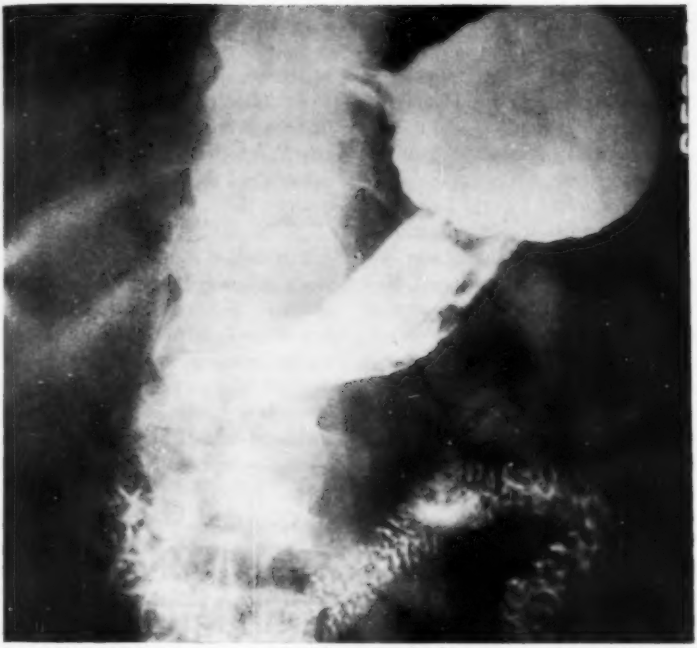


Fig. 2. In multiple x-ray exposures of the stomach, there is a consistent subtractive defect along the greater curvature in a polypoid configuration.

At this point, I would like to see the available radiographs.

Dr. K. D. McGinnis, Department of Radiology: A radiograph of the chest *(Fig. 1)* confirms the physical findings of bilateral elevation in both hemidiaphragms. There may be slight pleural effusion evidenced by "blunting" of the costophrenic sulci. The lung fields are slightly denser than usual in the bases suggesting compression by the high diaphragm.

Dr. Haubrich: Would you say that the contour of the hemidiaphragms is smooth and regular?

Dr. McGinnis: Yes. I see no evidence of focal lesion in the liver below altering this contour. The only additional examination performed was that of the proximal gastro-intestinal tract. This study was performed at a disadvantage because of the patient's precarious condition. No sign of varices was demonstrated in the distal esopha-

gus. In multiple exposures of the stomach *(Fig. 2)* there is a consistent subtractive defect along the greater curvature in a polypoid configuration. Peristalsis is said to have traversed this segment without impairment.

Dr. Haubrich: I could have done very nicely without this radiographic demonstration; the case was unravelling smoothly to this point. Now we must decide the significance of the filling defect within the stomach. My own differential diagnosis could include: heterotopic pancreas, granuloma, so-called "tumor-simulating gastritis," gastric varices, old blood clots, and neoplasm, either benign or malignant. It is unfortunate that, in this profoundly ill patient, further investigation was not feasible. However, we are reasonably safe in excluding the majority of possibilities which I have just named. It is my feeling that, in these radiographs, we are probably seeing a neoplasm. It has the appearance of benign adenomatous polyps, but I will confess that I cannot exclude a cancer.

The presence of this lesion within the stomach, of course, brings up the possibility of metastatic disease throughout the peritoneum and within the liver which conceivably could produce ascites, hepatomegaly, and weight loss such as exhibited by this patient. In order to help myself resolve the problem posed by this possibility, I have constructed the scheme in Table I.

Table I. A scheme for the differential diagnosis of ascites due to metastatic neoplasm in the liver and peritoneum and to cirrhosis.

	2° neoplasm	Cirrhosis
History	←	→
Physical Exam	liver, spleen	enlarged
	0	
Serum proteins	N	alb ↓ glob ↑
Cholesterol esters	N	↓
Serum bilirubin	N	sl ↑
Alk. phosphatase	↑	sl ↑
Flocs	0	+++
BSP	sl ↑	↑
Cell blocks	+	0
Liver biopsy		← →

Alkaline phosphatase

I will not dwell on the importance of the history which is self-evident. The physical characteristics of the liver to palpation may be misleading, but usually in cirrhosis the liver edge, while firm, is regular, whereas with neoplasm large masses within an enlarged liver often can be felt. Congestive splenomegaly will

be found with tumor only if the metastases fortuitously impinge on the splenic vein.

From the several "liver function tests," the alkaline phosphatase, cholesterol esters, and bromsulfalein retention have been the most helpful to me in this differential diagnosis. The alkaline phosphatase activity is not a *sensitive* sign of liver metastases, but, in the absence of jaundice, it is probably our most reliable index.

Was an aliquot of ascitic fluid from this patient submitted for cell block study?

Dr. Robert Birk, chief resident: It was, and no remarkable sediment was obtained.

Dr. Haubrich: Finally, needle biopsy of the liver may remain our most helpful tool. Among unselected patients harboring metastatic cancer in the liver (not limited solely to "problem" cases), needle biopsy will provide histologic proof of the neoplasm in about four-fifths.

Applying the suggested scheme of differential diagnosis in our present case, the facts at hand clearly favor cirrhosis.

In summary, I am impelled to postulate a diagnosis of cirrhosis of the Laennec-type. Complicating this disease were ascites and edema, probably pleural effusion, and (although there was no sign of hemorrhage) varices are likely to have been present. There was congestive splenomegaly. There may also have been a portal vein thrombosis; if so, it would have been of the gradual, only partially obliterative type. In any case of cirrhosis, particularly that exhibiting a relatively rapid deterioration, one must consider a

Fig. 3. Portal Cirrhosis

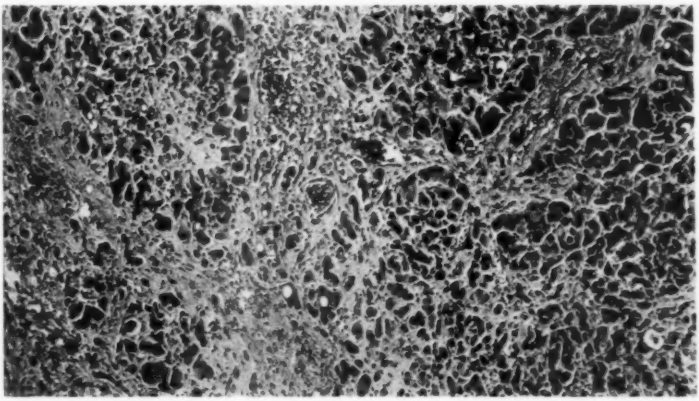


Fig. 4. Gastric Polyp

supervening primary liver-cell carcinoma (the so-called "hepatoma"). I can neither establish nor exclude this last possibility on the basis of evidence at hand.

The stomach lesion could have been a cancer, and there could be metastases in the liver, but I am content with the diagnosis of cirrhosis alone.

Why did the patient die? One might better ask how he could have lived. The liver, despite its remarkable reserve and regenerative power, is a vital organ, and its functional depletion is incompatible with life. Further, the metabolic effects of advanced liver disease on the brain are well established and profound, though obscure. This is in the abscence of any anatomically or histologically demonstrable change in the central nervous system. The pathologist will have also found pulmonary edema and a secondary pneumonia.

Dr. R. K. Nixon, Division of General Medicine: If this patient harbored cirrhosis alone, it is remarkable that the hemoglobin and erythrocyte count were so well maintained. We often find a definite anemia attending long-standing cirrhosis. One wonders, too, whether there might have been a vascular obstruction on the more proximal side of the portal venous system, i.e., of a Chiari's type or within the hepatic vein itself.

Dr. Haubrich: If a venous obstruction were present, I would expect it in the afferent (portal) side rather than in the efferent (hepatic) drainage.

Dr. R. C. Horn, pathologist-in-chief: The autopsy findings are precisely as our discussant has predicted, although those who were actually responsible for this patient's care considered the diagnosis of gastric carcinoma with extensive hepatic and peritoneal metastases

much more seriously than did Dr. Haubrich.

The significant findings were limited to the abdomen. The peritoneal cavity contained 2500 cc. of ascitic fluid. The liver weighed 1700 grams and was diffusely finely nodular. On section, it offered greatly increased resistance to the knife. Varices were striking in the distal portion of the esophagus, but there was no evidence of rupture or hemorrhage. Multiple polyps were noted in the antrum of the stomach along the greater curvature. The mucous membrane was intact over all of them, and their bases were not indurated. The largest, 2 cm. in diameter at its tip, was pedunculated. The only other findings worthy of note were bronchopneumonia and pulmonary edema. Splenomegaly was minimal.

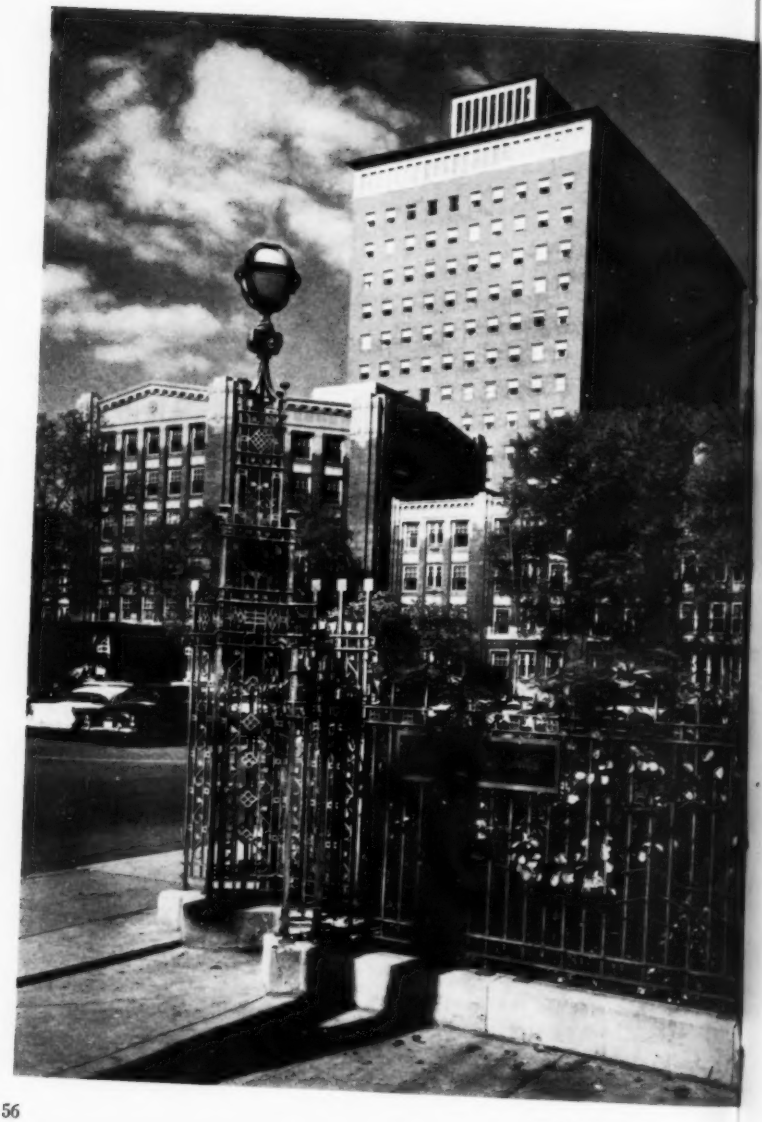
Microscopic examination showed the characteristic picture of Laennec's cirrhosis *(Fig. 3)* with heavy fibrous bands breaking up the parenchyma into pseudolobules. Bile duct proliferation and bile "lakes" were prominent. Little evidence of regeneration was noted. The gastric polyps were all similar, having stalks covered by normal mucosa and tips composed of increased numbers of large irregular glands *(Fig. 4)*. The appearance was much more suggestive of hyperplasia and inflammation than of neoplasis—as is usually the case with such polyps, in contrast to the much commoner ones of the colon and rectum. However, these gastric polyps are probably even more dangerous, so far as malignant potentialities are concerned. Both polyps and polypoid carcinomas of the stomach are practically invariably associated with advanced atrophic gastritis and this case is no exception.

FINAL ANATOMICAL DIAGNOSIS: *Portal cirrhosis of the liver with ascites and esophageal varices; multiple polyps of the stomach with atrophic gastritis; bronchopneumonia and pulmonary edema.*

Ob-Gyn Written Exam

THE NEXT SCHEDULED examinations (Part I), written, for all candidates for certification by the American Board of Obstetrics and Gynecology will be held in various cities of the United States, Canada, and military centers outside the Continental United States, on Friday, February 1, 1957, at 2:00 P.M.

Request for re-examination in Part II must be received prior to February 1, 1957. Bulletins outlining present requirements may be obtained from Robert L. Faulkner, M.D., Secretary, American Board of Obstetrics and Gynecology, 2105 Adelbert Road, Cleveland 6, Ohio.



Resident Physician

Henry Ford Hospital

Fourteenth in a series on resident centers

THE Henry Ford Hospital, centrally located within the City of Detroit, is a non-profit medical center comprising an 850-bed general medical and surgical hospital, outpatient clinic, research institute, and tuberculosis and psychiatric units.

In addition, the center houses a 24-hour emergency division for accident victims, as well as acute medical and surgical problems.

The hospital staff is composed of 400 physicians, including interns and residents, trained in the medical specialties as well as doctors of the basic sciences. Staff emphasis is on the total medical care of the patient, medical education at the graduate level, and medical research in the clinical and basic sciences.

Care

To support the hospital staff in providing comprehensive medical care for all types of patients, chronic and acute medical and surgical, the hospital and outpatient clinic are equipped with complete technical diagnostic and therapeutic instruments and equipment.

Many patients receive lifetime medical care from the doctors of the staff. Each patient is made to feel that he has a personal physician of his own choice who advises him about his medical problems. The administration and staff believes this concept is essential to quality medical care. At the same time, the patient is aware that specialists in every field of medicine and surgery are readily available to assist with complicated problems.

The large outpatient department supports a broad preventive health program. Ambulatory patients are encouraged to come to the outpatient department for complete examinations not only in the earliest stages of a disease process but even before any obvious symptoms are observed by the patient.

Hospital

Mr. Henry Ford and the Ford Family originally accepted the finan-

In the never-ending battle against disease and illness stand two great forces. At the bedside of the patient is the physician—bringing into play all the accumulated weight of his training, knowledge, and skill. In support of the physician is the pharmaceutical house—responsible for the consistent quality and purity of the medication prescribed.

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cial responsibility for the erection and operation of the hospital. The hospital was opened in October, 1915.

In keeping with the trend that patients today seek smaller room units than the ward, most accommodations at Henry Ford are private and semi-private.

In order to provide specialized nursing care and to have special equipment near at hand, some floors are arranged for specific medical problems while others are kept general in function. For example, most heart patients are together on the same floor. Similarly, orthopedic patients are usually grouped in a single area.

As in most hospitals of this size, pediatrics, obstetrical, tuberculosis, and psychiatric patients are accommodated in individual sections of the hospital. On the other hand, some floors are mixed medical and surgical patients, the emphasis being on the type of accommodation desired by the patient rather than the disease condition.

The hospital is connected to the outpatient department and in-patients are frequently taken to the clinics for technical procedures (such as x-ray, pulmonary function studies, consultation) since more exacting study can be made in the clinic than in the patient's room. The close physical relationship between the hospital and clinic gives the doctor easy access to the hospital floor when a problem or an emergency situation arises.

Outpatient department

The outpatient clinic of the Henry Ford Hospital is a seventeen story building housing the offices of the staff and their clinical suites. About two thousand patient visits are made

The teaching program at Henry Ford Hospital includes regularly scheduled teaching seminars such as the one pictured here on neurology and neurosurgery.

Dr. Oliver H. Gaebler, Director of Bio-Chemistry of the Edsel B. Ford Institute for Medical Research, checks information on the Institute's mass spectrometer.

each day to the various clinics of the outpatient department at the hospital.

While some hospital patients are also seen in the clinic for technical studies and for consultation, most patient visits are for ambulatory care.

Each medical and surgical specialty as well as general medical services are allocated to specific areas of the outpatient building. In this way the technical facilities and the trained personnel are economically located for optimum use by doctors and patients.

X-ray

One clinic floor consists entirely of x-ray facilities, both diagnostic and therapeutic, including a cobalt unit. These facilities are available to patients from both the hospital and the outpatient department. In other areas, such as orthopedics, cardiology and pulmonary, there are individual x-ray units allowing for

Residents find the modern reading room, located on the seventeenth floor of the clinic building, the perfect place for quiet study and reference work. Thick carpeting, acoustical tile, comfortable furniture, excellent lighting, all contribute to the attraction of this fine facility.

complete diagnostic work within the specialized clinic.

Laboratories

The same is true for laboratories. One floor of the clinic has a central laboratory for the majority of the studies of both the hospital and the ambulatory patient. Each clinic however may have a specialized laboratory within its own area. One floor is completely equipped with operating suites while another is largely a physical medicine and rehabilitation unit. Ample space is provided for the rehabilitation and training of patients to be functionally useful following accidents or illnesses.

Special medical services

As in other large medical centers, Henry Ford provides certain technical medical services which for practical reasons, cannot be incorporated into the average community hospital. One of these services is an audiology and speech rehabilitation center. The physical medicine, occupational therapy and rehabilitation unit is another important feature of modern medical care available at Henry Ford. The uses of radioisotopes employed at the hospital are established diagnostic and therapeutic technics, as yet, feasible only in the larger medical centers. The hospital's pulmonary function laboratory is another of the important adjunctive services.

Staff

As the scientific aspects of medicine have developed in the past two decades, it has become essential that the hospital medical-professional staff include the knowledge and the methods of the chemists, physicists, physiologists and social scientists in the study and the treatment of patients. The staff of the Henry Ford Hospital has some twenty doctors in the basic sciences to augment patient care, medical ed-

The "stacks" of the reference library contain more than 25,000 volumes.

Henry Ford Hospital Programs

PROGRAM	CHIEF
Internship	E. L. Quinn
Anesthesiology	Paul R. Dumke
Cardiology	John W. Keyes
Dermatology	Clarence S. Livingood
Gastroenterology	John G. Mateer
General Surgery	Laurence S. Fallis
Gynecology and Obstetrics	C. Paul Hodgkinson
Internal Medicine	John G. Mateer
Neurology	Lorne D. Proctor
Neurological Surgery	Robert S. Knighton
Ophthalmology	Jack S. Guyton
Oral Surgery	Fred Henny
Orthopedic Surgery	C. Leslie Mitchell
Otolaryngology	J. Lewis Dill
Pathological Anatomy and Clinical Pathology	Robert C. Horn
Pediatrics	J. A. Johnston
Plastic Surgery	Robert H. Clifford
Psychiatry	Lorne D. Proctor
Pulmonary Diseases	E. Osborne Coates
Radiology	William R. Eyler
Urology	A. Waite Bohne

ucation and clinical and basic science research.

As a medical institution which has a vital interest in teaching, the majority of the staff has been trained in specific fields. All branches of medicine and surgery are represented. Because the staff is interested in personalized medical care, an effort is made in the medical services to give the broadest type of such care.

At the present time the hospital, recognizing the need for doctors practicing in the general field of medicine, is developing a residency in general practice.

Graduate education

One of the important responsibilities of the large hospital is its medical education program. The staff of the Henry Ford Hospital believes "in an active and extensive teaching program."

"The educational effort is not only

Motion picture camera records surgical techniques during operative procedure at Henry Ford Hospital.

a responsibility for the training of young physicians and the advancement of the nation's health resources, but also the means by which the staff continues its own growth in medical knowledge.

"The training program of the hospital is primarily on the level of graduate medical education. It is the feeling of our staff that interns and residents are no longer students but are doctors seeking to advance their knowledge by graduate study."

The volume of patients in both the in-patient and outpatient departments, together with the supervision of the staff is the basis for the educational opportunity. Most of the training is conducted through daily contact with patients in the hospital and clinics, on teaching rounds, case teaching in conferences, seminars, and staff meetings. Also, some time is devoted to didactic instruction, particularly in the basic science seminars.

Both residents and interns are encouraged to assume responsibility in the management of patients and in every instance, try to gain the confidence of the patient as a major key to the practice of medicine. The medical educational program at the Henry Ford Hospital includes internship training and twenty approved residency programs.

Internship

Internship at Henry Ford Hospital is a rotating program in which forty positions are offered. The appointments, at a stipend of $200 a month, are made in conjunction with the matching plan.

The primary responsibility of the intern is in the management of patients in the in-patient department.

The intern is usually the first to see the patient, obtains complete medical history and physical examination. Next, the intern writes out his working diagnosis or a summary of the case and the initial orders for the investigation or treatment of the patient's problem. After conferring with his resident and the staff, the intern enters the orders in the patient's chart.

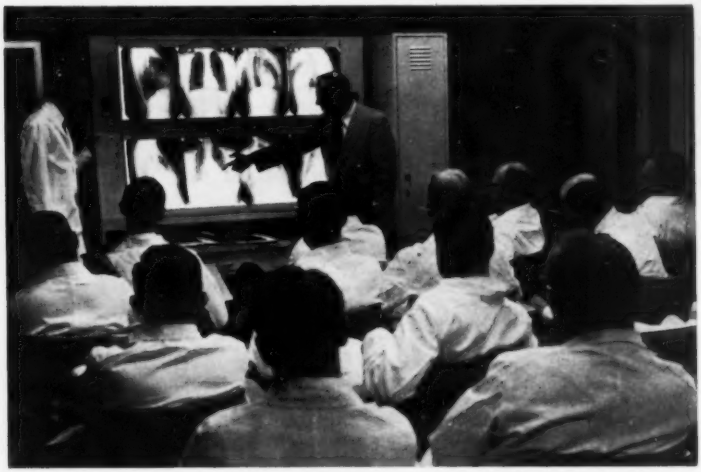
The intern is responsible for technican procedures such as thoracentesis or lumbar puncture as rapidly as he demonstrates his capability in performing them. For rounds and conferences, the intern is expected to prepare his cases for presentation and to participate in the discussion. He assists in the operating room and in the delivery room on the patients he has worked-up.

There is opportunity for outpatient follow-up on his patients both through duty at the clinic and in discussion with staff physicians concerning the patients' progress visits.

The emergency room affords the intern chances to learn the diagnosis and treatment of medical and surgical emergencies. Since the emergency room is open day and night there are many general medical and surgical problems the intern sees during this rotation.

Most of the laboratory work is performed by technicians although certain emergency procedures are

Dr. William R. Eyler, Radiologist-in-Chief, and Dr. Conrad R. Lam, Chief, Thoracic Surgery, hold a combined cardiology-radiology teaching conference for residents.



handled by the intern. Schedules for free time will vary from service to service but appropriate arrangements are made for each rotation. Night work is done mainly by the resident staff except on such services as obstetrics.

While the internship provides a full clinical experience, careful attention is paid to the case load of each intern. A subspecialty elective is given so that interns have an opportunity to look over a field of specific interest. And, as far as is practicable, each intern may elect to rotate early in the year to a service in which he might be interested for residency.

The rotational periods of the internship are:

Medical In-patient	**16 weeks**
Emergency Service	**19 days**
General Surgery	**8 weeks**
Pediatrics	**4 weeks**
Anesthesiology	**9 days**
Pathology and Clinical Pathology	**4 weeks**
Obstetrics	**4 weeks**
Surgical Subspecialty*	**8 weeks**
Elective (Vacation 2 weeks)	**4 weeks**

*Divisions of Urology, Ophthalmology, Gynecology, Orthopedics, Neurological Surgery, Otolaryngology.

Residency

For the most part, residents appointed to one of the graduate programs are appointed for the period of the full residency. In order to evaluate the resident, however, all appointments are reaffirmed on a yearly basis. When it is apparent that the resident should change his program of study, arrangements are made for him to enter a different residency program, taking into consideration the requirements of the specialty boards as well as open appointments.

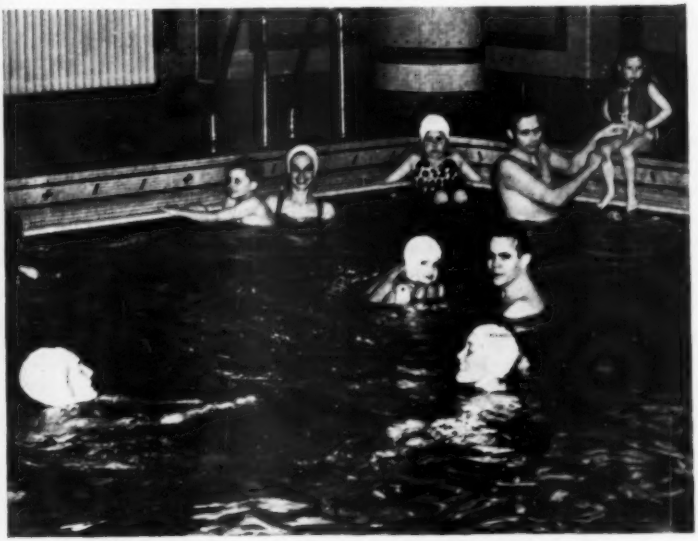
It is the feeling of the Henry Ford Hospital staff that residents in the graduate programs of the hospital should complete the requirements for licensure in the State of Michigan prior to the beginning of service. In Michigan, certification in the basic sciences is necessary before permanent licensure can be completed. It is believed that the resident realizes more of the responsibilities of the practicing physician if his licensure is placed in order immediately following his internship.

Responsibility

The current remuneration for the first-year resident is $225; the second-year resident, $275, and the third-year resident, $325 per month.

Each resident has daily responsibility for outpatients and hospital patients. In the outpatient department, the resident's patient appointments are seen under the supervision of the staff during his first year. His progression is directed toward seeing patients and carrying the responsibility for their care by himself in the final years of his program. The attending staff is al-

Food and conversation in the doctor's dining room.



Residents teach their children to swim at the hospital pool.

Conference Schedule

In the graduate medical educational program careful attention has been given to providing the intern and resident with a broad background on which to build his future practice. The general program is a part of the wide scope of training available to residents at Henry Ford to equip them for practice or for continuing their specialized medical education:

MEETING	PERIOD
Teaching Ward Rounds	Daily
Medical Staff	Weekly
Surgical Staff	Weekly
Divisional Conferences (from one to three meetings)	Weekly
Clinical Pathological Conferences	Weekly
Surgical Pathology	Weekly
Basic Science Seminar	Weekly
Clinical Radiology Conference	Weekly
Tumor Conference	Monthly
Hospital Medical Society	Monthly

ways in attendance to assist the resident. Daily rounds are made with the staff on all in-patients. The resident is expected to arrange his work so that he can attend the important teaching conferences and seminars each day.

Surgery

Although Henry Ford Hospital residency programs are conducted in twenty specialties and subspecialties of medicine and surgery, it would be impossible to list the various elements of each of these programs in this article.

Information

For further information on the residency programs at Henry Ford Hospital, write directly to the chief of the service in which you are interested.

The libraries

The medical library of the hospital contains over twenty-five thousand volumes. It receives about four hundred journals including important foreign clinical journals, basic science journals and journals from allied fields. The libraries are open every day except Sunday and every week day evening. The volumes and the journals may be removed from the library or they may be set up in bibliographical groups for study in the library. There are special small libraries in the research institute that may be used when a technical problem arises.

Research

An extensive program in both clinical and basic science research is being conducted at the hospital. There are some eighty different projects at the present time. Provisions are made for laboratories for

the clinical staff to pursue investigative work that has been approved by the research committee.

The Edsel B. Ford Institute for Medical Research has been engaged in research in the basic sciences for the past ten years. The Institute has a Department of Chemistry and a Department of Physics. While there is some collaborative work with the clinicians of the hospital, most of the work is limited to research in the basic sciences. At the present time, the doctors of the Institute are working on such projects as the metabolic effects of hormones, cholesterol metabolism, enzyme research, particularly succinic dehydrogenase, infra red spectra and x-ray diffraction identification of various steroids. The radioactive isotope laboratory of the hospital is located in the Institute.

The hospital bowling league rolls through its fifteenth season. Bowling on local alleys, hospital staffers find recreation and first class competition in the sport.

Indoctrination program

During the first few days of July, the new staff is assembled, members meet each other, learn the hospital's physical plant, and are generally acquainted with some of the hospital procedures. Each new doctor goes through patient registration, the physical examination, chest x-ray and routine laboratory work as though he were a new patient. A folder containing all the forms of the medical record as well as request forms for x-ray, laboratory procedures and consultations is given each man. He receives the hospital formulary and the hospital manual on pre- and post-operative patient management. Arrangements are made for lockers, laundry of uniforms and the completion of various personal records.

Soon after the beginning of the year, the new doctors and their wives are invited to the annual hospital picnic. The wives' club of the intern and resident staff usually has a garden party and tea for the wives of the new doctors.

Living quarters

For many years the hospital has felt that each intern and resident should have a home or apartment of his own in the community. It is be-

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For more than twenty-five years, PYRIDIUM has been employed to provide rapid pain relief for the patient suffering from pyelonephritis, cystitis, urethritis or prostatitis. In a matter of minutes, long before antibiotics, sulfonamides or other antibacterial measures can take effect, this nontoxic and widely-used urinary analgesic overcomes dysuria, frequency, urgency, nocturia or tenesmus. At the same time, PYRIDIUM imparts an orange-red color to the urine which gives the patient psychological assurance that PYRIDIUM is at work. Used alone or in combination, versatile PYRIDIUM may be readily adjusted to the need of a specific patient.

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lieved that this furthers the preparation of the young physician to live as a part of the community and to organize his future professional responsibilities. Obtaining suitable living quarters is not difficult, and the hospital maintains listings of available apartments, many of which have been used by previous interns and residents. For those residents and interns who may have duty in the hospital at night, sleeping rooms are provided.

Recreation

Among the most enthusiastic sportsmen of the staff are the bowlers. The hospital bowling league, in existence for fifteen years, has sixteen teams with a handicapping system to make all teams on an equal basis in competition. There is also a hospital soft ball team and a basketball team which competes in a city wide league. The hospital has a gymnasium for indoor activities. On the grounds are two tennis courts. For the swimmer there is a large indoor pool with a lifeguard on duty during the swimming hours. Some evening hours are set aside for the families of the staff to use the pool. Also, there are indoor handball and squash courts.

Socially, there are a number of yearly dances, informal parties, card parties, and meetings of wives' groups.

At graduation day ceremony, Dr. John G. Mateer, Physician-in-Chief, Henry Ford Hospital, offers congratulations and a certificate to intern, Dr. Phillip Hessburg.

Thoracic Surgery Board Requirements

The American Board of Thoracic Surgery held its first organizational meeting in October, 1948. It was formed by the cooperation of four national surgical societies which supplied representatives to form the Board. The American Association for Thoracic Surgery provided four members; the American College of Surgeons, and the Surgical Section of the American Medical Association, two members each. It was resolved that the American Board of Surgery would be the parent organization and would properly be in control of all matters pertaining to the training and certification of surgeons and surgical specialists.

Purposes

- In brief, the Board is set up to:

  Conduct examinations of satisfactory candidates who seek certification by the Board.
- Improve the opportunities for the training of thoracic surgeons.
- Set up principles of education to guide young surgeons who desire to prepare themselves for proficiency in thoracic surgery.
- Issue certificates of qualification to all those meeting the Board's requirements.

Basic requirements

Each applicant must be certified by the American Board of Surgery. Also required are:

- Two years training in thoracic surgery approved by the Board of Thoracic Surgery, or meritorious contributions to thoracic surgery. One of the two years may be spent during the four years of training in surgery required by the American Board of Surgery.
- Written, oral and practical examination.
- To qualify for the examination in thoracic surgery, the candidate shall have had two years of training in an active, well integrated thoracic surgical clinic or clinics, or the equivalent amount of thoracic surgical training, on a mixed service consisting of thoracic and non-thoracic surgical cases. Adequate training in both the tuberculous and non-tuberculous aspects of thoracic surgery is expected.

In order to obtain this objective, combined residencies between institutions of different types may be advantageous. It is also required that the candidate be familiar with the basic sciences as related to thoracic surgery. Under exceptional circumstances certain surgeons may, by virtue of recognized proficiency in the surgical treatment of thoracic diseases, qualify for the examination at the discretion of the Board.

Examination

The qualifying examinations are divided into two parts. Part I is written, and Part II is an oral examination in clinical surgery, x-ray interpretation and pathology.

Part I. This examination will be given simultaneously at least once a year in as many centers throughout the country as the Board may determine suitable for this purpose. It is an essay type of examination.

Part II. In order to be eligible for Part II, a candidate must have successfully completed Part I. Examinations in Part II are conducted in certain centers of the country selected by the Board. The examination takes two and a half hours

Re-examination

Candidates who fail Part I or Part II will be required to wait one year before they can retake the part which they failed. Those who fail twice will be required to wait for a period of two years. Candidates who are unsuccessful at three attempts will be required to wait three years before requesting reconsideration. The Board may at its discretion deny candidates the privilege of re-examination.

Candidates declared eligible but who fail to exercise the examination privilege within three years of the date of filing the application will be required to file a new and current application and pay a new examination fee. Also, a candidate who fails in an examination (Part I or Part II) and who does not apply for re-examination within three years shall be required to make a new application and pay a new examination fee.

Part I failure will require repeating of the entire part. Part II failure in clinical surgery also requires repeating the entire part.

Knowing exactly what's required often prevents confusion and costly misunderstandings. Here are essential facts for quick review. When your particular specialty appears, mark the cover and binding of the issue for ready reference.

The information contained in this article was obtained through direct correspondence with the specialty board. Current news such as changes in requirements, special announcements, and notices of date and place of examination will be published in *Resident Physician* as received from the various boards.

Failure of pathology or x-ray interpretation with a passing grade in clinical surgery requires the repetition of one or both of these parts.

Fees

For the special examination in thoracic surgery and the issuing of a certificate, the fee is $100. Of this fee, $15 is to accompany the application and will be considered as a registration fee. It is not returnable to the applicant in case he is disapproved for examination.

The fee for re-examination is $50.

Further information

Application forms and information may be obtained by writing to Wm. M. Tuttle, M.D., Secretary, the Board of Thoracic Surgery, 1151 Taylor Ave., Detroit 2, Michigan.

"We'll get an appendectomy down to five minutes yet."

CHRONICLE

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in the treatment of

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UROLOGISTS report the decided advantages of oral efficacy, minimal side effects, and wide range antibacterial activity offered by ACHROMYCIN in the treatment of urinary tract infections.

Finland's[1] group of patients with acute infections of the urinary tract (principally *E. coli*) demonstrated excellent response, both clinical and bacteriological, following administration of tetracycline.

Prigot and Marmell[2] reported 49 out of 50 patients with gonorrhea showed a negative smear and culture on the first post-treatment visit. Purulent discharge disappeared in these patients within 24 hours after a usual 1.5 Gm. dose of tetracycline.

Trafton and Lind[3] found tetracycline (ACHROMYCIN) an effective antibiotic for treating many urinary tract infections caused by both Gram-negative and Gram-positive organisms.

English, *et al.*[4] noted that a daily dose of 1 to 1.5 Gm. of tetracycline resulted in urinary levels as high as 1 mg. per milliliter.

To suit the needs of your practice and to further the patient's comfort ACHROMYCIN is offered in a complete line of 21 dosage forms.

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References:
1. Finland, M., *et al.*: *J.A.M.A.* 154:561 (Feb. 13) 1954.
2. Prigot, A. and Marmell, M. *Antibiotics and Chemotherapy* 4:1117 (Oct.) 1954.
3. Trafton, H. and Lind, H.: *idem* 4:697 (June) 1954.

Opportunities in Military Service

Another opinion on an important subject.

Max J. Trummer, LCDR (MC) USN

I once saw a quotation attributed to Dr. Menninger to the effect that if a man's time had been wasted while on military service, it was because the man had wasted it himself. Too many doctors enter military service with the fixed attitude that come what may, they will hate it. The end result is that the service suffers due to lowered performance and morale on the part of the doctor, and the doctor spends two miserable years—two irretrievable years out of his producttive life.

If a doctor will take a positive attitude towards military service, he will find innumerable opportunities to improve himself. Many opportunities will be thrust upon him; and more can be created in direct proportion to the personal ambition of the individual doctor.

Without an attempt at a detailed elaboration, I feel that certain rewards derived from military medical service are insufficiently emphasized.

Primarily, you enjoy the satisfaction that comes from serving your

ABOUT THE AUTHOR

A GRADUATE of University of Illinois College of Medicine (1948), the author interned at Methodist Hospital, Indianapolis, followed by a two-year general surgery residency at the VA Hospital, Hines, Ill. Military service included one year at the USN Hospital, Mare Island, Calif., one year aboard the USS Mountrail (APA 213), and three years at the USN Hospital, St. Albans, L. I., N. Y. The latter assignment included Dr. Trummer's third and fourth residency years in surgery. He is presently assigned to the Graduate School of Medicine, University of Pennsylvania, in the basic science course in surgery.

country well. In addition to being a commissioned officer and enjoying economic security, you will find a high standard of medical practice.

Once again, it rests upon the individual doctor as to what use he will make of the generous facilities provided.

Associations

Military service can make your interests and background cosmopolitan in breadth. This comes about not only through travel, but because professionally you are associated with graduates of every medical center in the country. You can distill out the best from each school of thought and apply it to your own practice.

Your circle of friends expands. I have always felt that I could find no finer friends than the line of officers of the Navy. Also, I have personally known doctors who made valuable contacts while on active duty, contacts which had a most important influence on their careers.

". . . In your July, 1956 issue appeared an article by Dr. Arthur L. Matles entitled 'Wait for the Draft . . . or Enlist Now?' It was an excellent summary of many factors bearing on the problem. I wish to disagree on one hand; and on the other, to add an important consideration which was omitted.

"These opinions are strictly my own. They are based on thirteen years' association with the Navy, over five of which have been spent on active duty as a medical officer. I have no connection with recruiting except insofar as I am an ardent booster for the Navy Medical Corps.

"I take issue with the basic premise of the article, to wit: That military service is a fate worse than death for a physician."

M.J.T.

Outstanding training

The Navy offers outstanding training in its internship and residency programs. My internship at a 720-bed private hospital couldn't compare with that at the U. S. Naval Hospital, St. Albans, New York (where I just completed a surgical residency). These programs are doubly attractive because of the pay and the fact that the total time spent in training and in subsequent obligated duty is frequently no more than the total of time spent in civilian institutions, and covering a wide range of subjects in medicine and allied fields.

There are also opportunities not available in civilian medical practice, of which aviation medicine and submarine and diving medicine are prime examples.

A Navy doctor who can interest himself in his environment will find fascinating subjects to study aboard ship which will dispel monotony,

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stimulate his mind, and perhaps eventually serve as pleasant hobbies for many years to come. At many military stations outstanding recreational facilities are available at little or no cost.

Family

In his article, Dr. Matles failed to mention perhaps the most important factor in a man's adjustment to military service: His family.

A single man has few problems compared to a family man. And during the discernible future, when every doctor faces inevitable military service, procrastination in fulfilling that duty will only work additional hardship on the family man. Besides additional financial commitments which he will have assumed, his family will have enlarged, some children will be of school age, and his wife will be less inclined to move about, which she might have done happily in less encumbered years. And the doctor himself will have become less flexible.

Enlist or wait?

I would answer the question of "Wait for the Draft . . . or Enlist Now?" as follows: If possible, take your internship in the service. Strongly consider residency training also. If you do not choose to do this, enlist after one year of residency. This will give you some specialty status and added valuable experience. Then upon your return to civilian life you can complete your training and establish your contacts for practice without interruption.

And, when you announce that you will be wearing your country's uniform, say it with pride, doctor!

"For the physician it is unquestionably an important point to have a fine appearance and to be well nourished, because the public believes that those who do not know how to take care of their own bodies are not in a position to think about the care of others. He should know how to be silent at the proper moment and should conduct a regular life, because this contributes much to his good reputation. His behavior should be that of an honest man and as such he should appear gentle and tolerant before honest men. He should not act impulsively nor precipitately; he should maintain a calm and serene visage and should never be in bad humor, but on the other hand should not appear too gay."

HIPPOCRATES

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'Ilotycin' kills susceptible pathogens of the respiratory tract. Therefore, the response is decisive and quick. Bacterial complications such as otitis media, chronic tonsillitis, and pyelitis are less likely to occur.

'Ilotycin' is notably safe and well tolerated. Staphylococcus enteritis and avitaminosis have not been encountered.

With usual dosages, gastro-intestinal hypermotility is not observed in bed patients and is seen in only a small percentage of ambulant patients.

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CHRISTMAS
Facts and Fancies

Our present-day heritage of Christmas merriment includes many legends and customs. Here are a few authentic bits of background on the origins of some of these traditions linked with this holiday week.

Christmas is, to the Christian world, the celebration of the birthday of Christ Jesus, the Son of God. It is a time of prayer, of hope, of happiness in homes and hospitals throughout the U. S.

It is a day and a season; a joyous time full of ancient traditions and customs which have been willed to us, through the ages, by the peoples of many lands. From the ancient Druids of Britain and the tribes of Northern Europe to the medieval English and early American colonists, there has been an enduring bequest of lovely legends and gay traditions which make our own Christmas such a merry and enchanting occasion.

For example, as a resident, you may be interested to know that mistletoe is a kissin' cousin to medicine.

The popular custom of kissing under the mistletoe comes down to us from the mystic rites of the primitive Druids. In their faraway age, the mistletoe, which means "all heal," was believed to have magic qualities — the power to protect its possessor from witchcraft, heal disease, neutralize poisons, and bestow fertility on humans and animals.

If a young couple sealed their betrothal with a kiss under the mistletoe, they would receive wonderful blessings and much good luck for the rest of their lives.

This custom has lived for over 2,000 years and continues to live today with much merry conjecture as to who will get "caught" under the mistletoe at Christmas. Actually, mistletoe today is often utilized by the shy male as somewhat of a "command performance" — a perfect excuse to engage in a tender art, and, of course, it may be employed in the nature of "the tender trap," set by the impatient female to force the laggard male into his first step on the path of romance.

Christmas tree

And what Yuletide celebration would be complete without the traditional Christmas tree. It is to the old Teutonic belief that the trees of the forest were inhabited by god-like spirits, that we are indebted for this gay holiday decoration in our homes.

In order to appease these "spirits," the Germans brought the trees into their homes to show them they were welcome at the Winter Solstice ceremonies.

Yule log

The holiday season as we know it today consists mainly of Christmas and the New Year and their respective eves. However, throughout the whole octave of the season, there exists a festive spirit. This extended happy atmosphere comes to us from the Medieval English who celebrated Christmas not just for four days, but for twelve. And the "Twelve Days of Christmas" were signalled by the lighting of the Yule Log. As the log was drawn into the hall of the lord, the people of the manor would gather 'round to sing joyful songs and carols. The log would then be lit and the fire kept burning for twelve days. At the end of the twelfth day, it would be extinguished and a remnant of the fire kept for the following year when it would be used to kindle a new log. Thus, we find the symbolism of the Yule Log and the reason why Christmas is often referred to as "Yuletide."

Holly

The sprightly carol "Deck the hall with boughs of holly . . .", today a must in any choral group repertoire, was also sung by the people of Medieval England as they gathered to salute the Yule Log. And the opening lines of the carol were literally true. The use of holly as a Christmas decoration in those days was quite popular and has remained a symbol of the festive Christmas spirit throughout the centuries. There was also a more practical use for holly. In days gone by, unmarried women fastened a sprig of holly to their beds at Christmastime to protect them from the "evil one" during the coming year.

Santa

The English, however, are not the only ones to leave us enduring traditions. "Santa Claus" was given us by the Dutch whose "Santa Klass" was a contraction for St. Nicholas, the patron saint of children. The Dutch also began the charming custom of hanging children's stockings in anticipation of the jolly saint's annual visit.

But one of our most popular holiday activities, and one few of us would miss, is the visiting of friends and relatives during the Christmas-New Year's week. We owe this custom to the early Dutch settlers of New Amsterdam. On New Year's Day, every young Dutch maiden would wear her best jeweled cap and her most delicately pleated ruff,


MERRY CHRISTMAS
AND A
HAPPY NEW YEAR
FROM THE
PUBLISHER, EDITORS
AND
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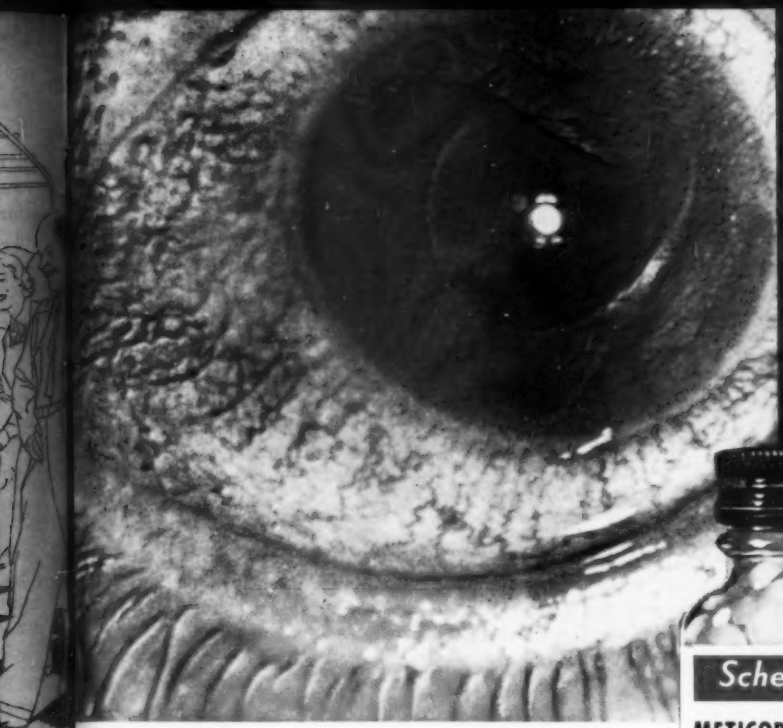

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and seated in the front room among her family treasures, await the coming of those youths socially eligible to become her husband. No doubt she served them refreshments and, of course, there must have been much toasting to welcome in the New Year. Through the years, this quaint Dutch custom has been modified until today the suitors have all but disappeared, and, in their stead, friends and relatives assemble in warm celebration of the holiday festivities.

Christmas dinner . . .

But, regardless of what age or in what land it was being observed, Christmas has always been a time of family reunion and feasting. In the time of Elizabeth I, a Christmas dinner often lasted as long as nine hours, with further snacks of oysters and pheasant served throughout the evening. One of the main dishes of the banquet was a peacock brought in on a golden platter, its crested head erect and its tail gracefully outspread. As a companion there might be a steaming boar's head, with a bright, red apple set between its sharp, gleaming teeth.

. . . And pudding

And what Christmas dinner would be complete in the merrie England of Good Queen Bess without plum pudding! The origins of this festive dessert are lost in history but popular legend explains it this way: Once upon a time, an English king went hunting on Christmas Eve. He soon became lost, however, when a blizzard blocked the paths of the forest. One of the hunters, the cook, very quickly found himself charged with the task of preparing Christmas dinner from whatever food he could find. So he literally threw everything into the pot — the remains of a stag chopped into fine bits, flour, a few dried plums, some birds' eggs, ale, brandy, a bit of sugar and meat from some wild game. (No king went hunting without a few simple provisions.) Soon, to his surprise and pleasure, he had a delicious, hot "pudding." And to this day, true plum puddings have all of these ingredients which our quick-witted (and well supplied) hunter put into his cooking-pot.

. . . And pie

Another favorite dinner treat with an interesting beginning is Mince Meat Pie. This tasty dish was originally devised by the Puritans as a religious offering and served with a tiny figure of the Christ child in its center. The earliest known recipe dates from the reign of James I in the early 17th century. At that time the pie was filled with beef tongue, chopped chicken, eggs, raisins, orange and lemon peelings, sugar and various spices.

. . . And pungent ale

The custom of inviting friends and relatives in for cocktails during the holiday season, so popular in Amer-

ica today, dates back to the old English practice of "wassailing." In Elizabethan times, no celebration was complete without the wassail bowl filled to the brim with hot pungent ale—a cheery invitation to all to come in and help celebrate the Yule. Then, as the guests raised their steaming mugs in a toast to Christmas, the merry cry of "What Hail!" "Wassail!" would ring joyously through the hall.

Hot punches, even today, are especially invigorating drinks. Newly revived in popularity among Americans, they have never gone out of favor in England where punch bowls are a frequent sight, usually of polished silver to hold hot brews. These zesty punches may be mild or glowing.

Christmas today means many things for Americans. It is not only Santa Claus and mistletoe, plum pudding and "togetherness," but a whole heritage of festive traditions and age-old customs which have blended so well with the American scene. When we say "Merry Christmas," it is indeed so, because it is the true gift of friendship and love from many ages and lands.

Our thanks to the Browne Vintners Co., Inc., for their cooperation in preparing this article.

Medicine Board Exams

JANUARY 2, 1957, is the closing date for acceptance of applications for the American Board of Internal Medicine *oral examination* to be held in New Orleans (February 4-8, 1957) and Boston (April 3-6, 1957). However, candidates who expect to take their orals in Chicago (May 27-29, 1957), San Francisco or Los Angeles (exact dates to be announced later), have until February 1, 1957.

The *written examination* will be held October 21, 1957, for all candidates. Applications close May 1, 1957.

The Pharmacist On Your Team

Those who practice the health professions accomplish most when they work together as a team, each performing his own duties to the best of his ability while understanding and respecting the efforts of his teammates. Here is part of the pharmacist's role in aiding his teammate, the physician.

Mearl D. Pritchard, Ph.G.

Rrrrrring-----

"Good morning! Jones Pharmacy. Calvin Jones speaking."

"Good morning, Cal, this is Hal Cullen."

"Yes, doctor, what can we do for you?"

"I read an article in the Journal last night about a drug called——————. It seems to fit the need of a certain patient of mine. Is it available?"

"Probably new or marketed under a trade name, Hal. Let me look in my files, just hold the wire a moment———————— Yes, it *is* new but it is available under the name of ———————— and comes in 10 mg and 25 mg tablets. We have condensed literature here. Can I give you any other information about it?"

"No, thanks, the article gave me sufficient information for now. Do you have any on hand?"

"Yes, we do."

"Fine. I'll stop by this noon."

New products

Such phone conversations are common in the pharmacy today. The flood of new products has both the pharmacist and physician searching for ways in which to sift the wheat from the chaff.

Each year some 400 new medicines are brought into the ethical market. Hundreds more standard prescription products appear in new forms, dosages and other variations

of formula. Duplications are inevitable. And the accelerated speed of pharmaceutical research leaves in its wake thousands of products which have been superseded, improved, or fail to measure up to their fullest expectations.

Information, inventory

Thus the pharmacist, since he deals with physicians in many of the specialties of medical practice, must keep as complete an information file as possible. In addition, he must stock many of the new items. To do the latter, the pharmacist arranges with the major companies to send him a small supply of all new products as soon as they are released. This is accomplished on what is termed "automatic shipment," that is, without any specific order being sent to the manufacturer, the pharmacist will automatically receive a quantity of each new item.

The automatic shipment inventory embraces only a small percentage of the total of new products, however.

Consultant

For the other new products and variations of standard products, the pharmacist generally will discuss particular items with the physician and order on the physician's request or on the indicated demand.

As a member of the health team, then, the pharmacist acts as an information center, a local warehouse geared to the immediate physician community, and a professional consultant on pharmaceuticals available to the physician.

Service

Again, let's listen in on the extension at Jones' Pharmacy — Cal Jones is speaking.

"Mrs. Allen, have you talked with

About the Author—A graduate of the University of Buffalo School of Pharmacy, the author has owned and operated a pharmacy in Buffalo, New York, for the past 30 years. Formerly an instructor at his alma mater, he is currently serving his second four-year term as a member of the Council of the University and last year completed a one-year-term as president of the university's General Alumni Board. Mr. Pritchard was a first vice-president of the American Pharmaceutical Association (1948-1949), president of the Erie County Pharmaceutical Association (1950-1951), and president of the American College of Apothecaries (1955-1956). Recipient of numerous awards for his service to pharmacy and pharmaceutical education, the author is also an active citizen and booster of Buffalo. He is past director of the Buffalo Chamber of Commerce and is currently president of the Buffalo Better Business Bureau. "I am almost afraid," he writes, "to give you a list of my associations for fear of being over-estimated. I am just a local pharmacist who has tried to be a good citizen, a member of the community health team, and a worker in pharmaceutical organizations."

Doctor Summers about taking more of this medicine?"

"Why, no. It did wonders for me last fall, and I want to take it again because I have a reoccurrence of the same trouble. I just want a refill, that's all."

"Well, as you know, Mrs. Allen, conditions change and also, new pharmaceuticals come into the picture constantly. I would feel much easier about it if you'd do me a favor. Would you call Doctor Summers first?"

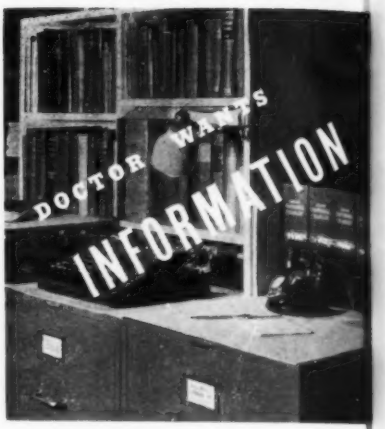
"Well . . . maybe that would be wiser. Thank you, Mr. Jones. I'll call you back."

Cal Jones did not tell Mrs. Allen that Dr. Summers had given no refill instructions and, furthermore, he suspected that **Mrs. Allen might** need medical attention.

Was this a service to the physician? Indirectly, yes. Primarily, it was the ethical and *legal* thing to do, protecting the patient of the physician, as well as the physician and the pharmacist. It was a case of teamwork in health.

Refills

The question of refilling prescriptions is an important one. The refilling of a doctor's prescription was, at one time, almost a custom. Self-medication through the use of medicines prescribed months or years before, sometimes for another member of the family (or even a friend) was a common circumstance. Too common. A few years ago, the danger was not nearly as great as it would be today with the potent medications now available.



Law

Thus, in 1951, the Humphrey-Durham Amendment to the Food and Drug Act was passed by Congress. Now, under the law, a prescription for drugs restricted to prescription use is not refillable unless the physician so indicates on the prescription. The physician may write "refill once," "refill ——— times," or "refill for —— months." In a few cases he may wish to instruct, "refill as needed."

The pharmacist must use good professional judgment in emergencies; also he must be quick to spot misuse of medicines. His interest is "the welfare of the patient" and

"to keep the good will of the patient" for both the doctor and himself.

Public relations

Most young physicians — and many who have been in practice for many years — are unaware of the size of the public relations effort the pharmacist puts forth on behalf of the physician. Probably the most important instances of this occur with the patient who feels the drug prescribed is too costly. This is a common situation today, especially in the antibiotic and hormone preparations.

"Surely there must be something cheaper he could prescribe," the patient complains.

Rarely is this complaint aired before the physician. The normal course is for the patient to talk about the physician to the pharmacist, especially where it concerns "these high-priced drugs he's always prescribing. . . ."

Complaint

The present-day professional pharmacist is able to deal with this type of complaint—and does.

Depending upon the irritated patient, the pharmacist may answer, "To be perfectly honest, Mr. Blank, this medicine is probably the biggest bargain of your life. You see, we have become accustomed to these marvelous medications, take them for granted. We often forget their value in terms of speedier recovery. Hospital stays are prevented or shortened considerably. Even your physician's visits are held to a far lower rate than was the case before these drugs were discovered. This prescription you have is expensive to manufacture—but I think you'll agree it's worth every cent you pay for it. And, since the doctor's primary interest is to help you get well as quickly as possible, he has selected this particular compound to help you do just that."

Compounding

What about the "art of compounding" — is it lost? By no means. Here is a real service rendered physician and patient by the pharmacist. True, over 90% of the prescriptions dispensed today are for "ready made" medicines but there is always the need for a "custom

made" prescription properly adjusted to the individual needs of the patient. This is particularly true in the practice of dermatology and ophthalmology.

Pharmacy graduates are the product of four years of intensive training for which they receive a bachelor of science degree. After 1960, this training will be extended to five years. Given an opportunity, these pharmacists will prove that they can prepare effective, stable and acceptable medication made to order for the individual when the need is present. Sometimes, it is economically advantageous. This is, indeed, one of the pharmacist's jobs on the health team.

Supplies

One final service that helps make the health team effective is the ability of the pharmacist to furnish promptly, office supplies, gauze, injectables, dressings, etc., in small quantities. This keeps the doctor's office inventory down.

The pharmacist knows the value of low inventories and quick turnover in his own business and he can show his physicians the advantage of buying often where they can obtain prompt and efficient service.

The old complaint of "prescribing pharmacists" and "dispensing physicians" will pass with the older men in both professions. Perhaps 90% of this difficulty, where it exists, could be eliminated if physicians and pharmacists would meet on the local level and have a frank discussion of the matter.

Chief duties

To summarize the pharmacist's chief duties on the health team:

- The pharmacist serves as a consultant on new drugs.
- He can be a reliable source of supply for drugs the physician wishes to prescribe if the physician keeps him informed of his preferences.
- He guards against misuse of prescription medication and acts as a good will agent for the doctor.
- He supplies, quickly and economically, many office needs.
- He is, first and last, a pharmacist trained in the art of compounding and able to assist the physician when he needs special medication for his patients.
- Finally, it has been the observation of this writer that a close personal and professional relationship between physician and pharmacist will develop a team that works effectively to preserve the health and welfare of the community, and make working together a real pleasure.

What's the Doctor's Name?

By Victor R. Jablokow, M.D.

He was born at Kayserberg, in Upper Alsace, on January 14, 1875. His father was the pastor and the teacher of a small evangelical community in his home town. In 1900, he took degrees in theology and in philosophy at the University of Strasbourg and obtained a post at the Church of St. Nicholas, first as a deacon and later as a curate.

* * *

In 1904, he read an article in the Paris "Journal des Missions Evangeliques" about the desperate conditions of the Negroes in French Equatorial Africa. He then decided to study medicine with the idea of going there as a doctor. He was 30 at this time, and had already achieved a world-wide reputation in philosophy and theology as well as in music.

Before leaving Europe, he married Helen Bresslau, the daughter of a Strasbourg historian. Helen was a trained nurse and offered valuable help in his subsequent work.

* * *

In 1911, he took his medical degree and went to Africa where he established a hospital at Lambaréné. The hospital was supported by funds obtained through organ concerts which he gave on his periodic trips to Europe and by gifts received from many countries. In spite of the strenuous work at the hospital he found time to work on his philosophical and other writings.

* * *

He has written more than a dozen books ranging from theological treatises and a monumental biography of Johann Sebastian Bach to a multi-volume work entitled "The Philosophy of Civilization."

* * *

Through his interest in organ music he became an authority on organs, especially on their preservation and reconstruction. He is also an expert on the life of Bach and a superlative interpreter of his organ works, of which he has recorded a great number.

* * *

He was awarded the 1952 Nobel Peace Prize.

* * *

He is 81 years old and still actively engaged in his work.

Can you name the doctor without turning to page 112?

A new outstanding therapeutic agent discovered and developed by Pfizer scientists to meet the problem of resistant staphylococci and to control superinfection with these strains.

Matromycin has been shown to be outstandingly effective against antibiotic-resistant fresh clinical isolates of *M. pyogenes.*[1] Marked susceptibility of most erythromycin-resistant strains of staphylococci, particularly fresh clinical isolates, indicates no predictable cross-resistance with erythromycin. This is also true for tetracycline, oxytetracycline, chlortetracycline, penicillin and streptomycin.[2] Effectiveness of Matromycin against antibiotic-resistant strains is complemented by the fact that resistance to Matromycin itself does not readily occur.[1] Clinical trials reveal Matromycin to be both effective and well tolerated when employed against infections due to susceptible organisms.[2]

Capsules, 250 mg.; bottles of 16.

1. Noyes, H. E.; Nagle, S. C., Jr.; Sanford, J. P., and Robbins, M. L.: Antibiotics & Chemother. *6*:450 (July) 1956. 2. Ross, S.: Antibiotics Annual 1955-1956, New York, Medical Encyclopedia, Inc., 1956, p. 600.

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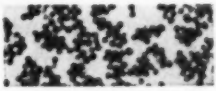
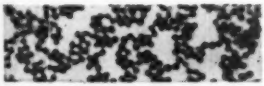
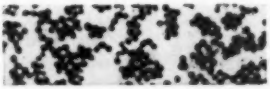
when sensitivity   testing reveals infection due to resistant staphylococci 

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Division, Chas. Pfizer & Co., Inc.

Mediquiz

1. A fifty-five year old man presents himself for advice with the following information.

Present history: For the past year he has had vague abdominal symptoms of flatulence, belching, dysphagia, distress after meals and frequent bowel movements (up to ten daily) normal in consistency and appearance. Appetite has remained good. He has gained fifteen pounds in weight. He has complained of frequent sub-occipital headaches. Rapid palpitations, increased sweating and momentary sharp pain lateral to the left nipple have been noticed at home. His sleep has been restless. He frequently gets up at night and eats a cracker which, he says, quiets him and permits him to sleep better.

Past history: Usual childhood exanthemata with no residua.

Family history: Father died at age 56 of carcinoma of the stomach. Mother died at 79 of congestive heart failure. Only brother, who had been living with him, died of metastatic carcinoma two years previously at age 50.

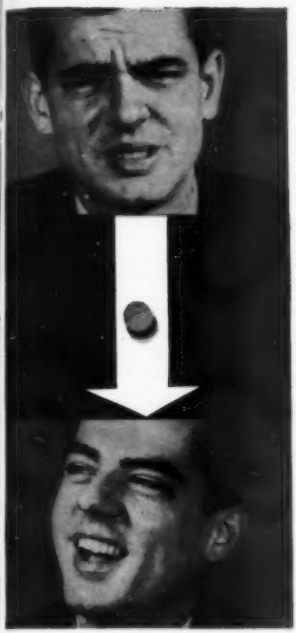
Physical examination: A rather apprehensive male of 55, obese, in no acute distress. Positive findings: Pulse varies 76-110, sinus arrhythmia, blood pressure 160-140 systolic, 80-70 diastolic.

The one of the following which might explain all these symptoms is: (A) hypothyroidism; (B) hypertensive heart disease with anginal syndrome; (C) carcinoma of the stomach; (D) anxiety state.

2. In question number one, if the patient has hyperthyroidism, all symptoms could be explained on that condition alone except for: (A) frequent bowel movements; (B) gain in weight; (C) palpitation; (D) restlessness at night.

3. In question one, if the patient has hypertensive heart disease, the one of the following laboratory findings which would help establish the diagnosis is: (A) protein in urine; (B) increase in blood urea; (C) fixation of urinary specific gravity; (D) cardiac enlargement on x-ray.

4. In question number one, if you suspect carcinoma of the stomach, the one of the following laboratory findings which would be of greatest significance is: (A) erythrocyte sedimentation rate increased; (B) decrease in white blood count; (C)



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achlorhydria; (D) occult blood in stool.

5. In question number one, if the patient is suffering from anxiety state, he will show: (A) equal and overactive knee jerks; (B) dorsiflexion of great toe in plantar reflex; (C) unequal pupils; (D) absent cremasteric reflexes.

6. The one of the following courses which would be most helpful in determining whether or not the diagnosis (in question number one) should be anxiety state is: (A) obtaining further history; (B) finding a normal stomach on radiographic study; (C) finding a normal electrocardiogram; (D) finding an absent gag reflex.

7. In young patients with rheumatic heart disease, the most frequent of the following causes of heart failure is: (A) overexertion; (B) active rheumatic carditis; (C) emotional trauma; (D) pericardial effusion.

8. The most common cause of right ventricular failure is: (A) tight mitral stenosis; (B) advanced cor pulmonale; (C) pulmonary stenosis; (D) left ventricular failure.

9. The diagnosis of mitral insufficiency in a young patient is justified if there is a systolic murmur at the apex which is: (A) loud and harsh; (B) transmitted; (C) associated with cardiac enlargement; (D) accompanied by a loud third sound.

10. Clinically, auricular fibrillation must be differentiated from: (A) auricular flutter with complete A-V block; (B) auricular flutter with 1 to 4 ventricular response; (C) auricular flutter with varying ventricular response; (D) normal sinus rhythm with alternating left bundle branch block.

11. Generalized arteriolar vasoconstriction causes an increase principally in: (A) systolic blood pressure; (B) diastolic blood pressure; (C) pulse pressure; (D) capillary blood pressure.

12. Radiographically, the characteristic shape of the cardiac silhouette in well-established hypertensive heart disease is: (A) boot shape; (B) water bottle shape; (C) straightened left border due to obliteration of the cardiovascular angle; (D) caused by prominence of the pulmonary conus.

13. Of the following diseases, the one most likely to be followed by glomerular nephritis is: (A) mumps; (B) diphtheria; (C) chicken pox; (D) scarlet fever.

14. Of the following diseases, the one in which increased titre of heterophile antibodies is an important

diagnostic aid is: (A) typhus fever; (B) infectious mononucleosis; (C) lymphocytic choriomeningitis; (D) influenza.

15. Of the following diseases, the one in which perforation of the bowel is most likely to occur is: (A) amebiasis; (B) bacillary dysentery; (C) typhoid fever; (D) typhus fever.

16. Of the following diseases, the one in which a marked leukocytosis is most likely to be found is: (A) lobar pneumonia; (B) primary atypical pneumonia; (C) pulmonary tuberculosis; (D) influenza.

17. Of the following diseases, the one in which a moderate leucopenia is most characteristic is: (A) Weil's disease; (B) brucellosis; (C) actinomycosis; (D) scarlet fever.

18. Of the following, the one in which fever with recurring skin lesion simulating erythema-nodosum is most commonly seen is: (A) paratyphoid infections; (B) chronic meningococcus sepsis; (C) malaria; (D) lymphogranuloma venereum.

19. Erysipelas is commonly associated with infection by: (A) staphylococcus aureus; (B) H. influenzae; (C) escherichia coli; (D) streptococcus hemolyticus.

20. The one of the following conditions in which the basal metabolic rate is not likely to be elevated is: (A) metastatic carcinoma of the cervical lymph glands; (B) Hodgkin's disease; (C) lymphosarcoma; (D) acute lymphatic leukemia.

21. Of the following results, the one which is obtained after a section of the vagus nerves for peptic ulcer is that it: (A) increases nocturnal secretion in the stomach; (B) increases the motility of the stomach; (C) diminishes the nocturnal secretion from the stomach; (D) has no effect on the nocturnal secretion of the stomach.

22. In an indirect inguinal hernia the relation of the sac at the neck to the deep epigastric artery is that the sac lies: (A) lateral to the artery; (B) medial to the artery; (C) posterior to the artery; (D) anterior to the artery.

23. The effect of prolonged ascorbic acid depletion in a healing wound is: (A) increase of collagen and reticulum; (B) no increase of collagen formation; (C) lack of collagen and reticulum; (D) no change in reticulum.

24. The one of the following conditions with which osteitis fibrosa cystica is usually associated is: (A) hyperthryoidism; (B) hyperparathyroidism; (C) Addison's disease; (D) hypothyroidism.

Answers on page 112

Classified Advertising

Leads and Needs

Rates

Personal classified advertising rates are $3.00 for ads of thirty words or less plus 10c for each additional word. When a box number is used and answers sent care of RESIDENT PHYSICIAN there is an additional charge of 50c. Add four additional words for a box.

For semi-display ads set in bold face, the rate is $3.75 for 30 words or less, plus 15c for each additional word.

Commercial classified rates are $4.50 for ads of twenty words or less plus 15c for each additional word. Commercial rates include all ads of manufacturers, dealers, agencies etc. Count four additional words for a box.

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ALL CLASSIFIED ADS PAYABLE IN ADVANCE. Forms close 15th of month prior to date of issue. RESIDENT PHYSICIAN, 1447 Northern Boulevard, Manhasset, New York.

PHYSICIANS WANTED

EXCEPTIONAL OPPORTUNITIES — General Practice and anesthesia; Plymouth, Culver and Argos, Indiana; county hospital addition being built; ethics, congeniality, rapport, vigor and sincerity of area physicians unexcelled. For complete information contact: James F. Rimel, M.D. Secretary, Marshall County Medical Society, Plymouth, Indiana.

ASSOCIATE WANTED: Qualified internist, pediatrician or general practitioner; ethical 25 bed clinic-hospital; air-conditioned; excellent present and future; adequate time off for study and relaxation; no investment; beautiful county seat of 8000; industrial and farming; percentage commensurate with experience; answer only if definitely interested. Dr. E. Finger, Marion, South Carolina.

PSYCHIATRISTS AND PHYSICIANS WANTED —State Hospital South, Blackfoot, Idaho; Board eligible or experienced psychiatrists and physicians wanted; opening in research and education, clinical director, or staff; must be eligible for Idaho license; opportunity for limited private practice; out-patient department; salary open, maintenance available; 2 weeks vacation, holidays, sick leave, social security; hunting; fishing and recreation excellent. Contact S. Wayne Smith, M.D., Superintendent, Box 390, Blackfoot, Idaho.

PHYSICIANS WANTED

ANESTHESIOLOGISTS—Three full time Senior positions available for anesthesiologists in University Hospitals of Cleveland, Ohio, in September and December 1956; opportunities for clinical anesthesia, resident and medical student teaching and research in this developing department, now operated by a group of 10 physician anesthesiologists. Interested applicants write to: Robert A. Hingson, M.D., Director, Department of Anesthesia, University Hospitals of Cleveland, 2065 Adelbert Road, Cleveland 6, Ohio.

PHYSICIANS WANTED: Prosperous Northwestern Indiana community; new 14 room clinic ready by October; attractive proposition for the right individuals; 20 minutes to hospitals. Community Development Corporation of DeMotte, Indiana.

PHYSICIANS wanted: General Practice; interested in permanent partnership association; salary 1st. year, opportunity to buy in if agreeable to other partners. McCallpIvy Hospital and Clinic, Weslaco, Texas.

PEDIATRICIAN AND OB MAN: BOARD QUALIFIED, needed; now 4 man clinic; established location; across from bank. Dr. B. C. Pippin, 925 Britton Road, Oklahoma City, Oklahoma.

MICHIGAN—Excellent Opportunity; for General Practitioner to take over equipped 5 room office and established practice; would like to sell equipment to successor. 304 Evergreen, suite 12, East Lansing, Michigan.

OTOLARYNGOLOGIST: for Staff of Group Practice Clinic; serving membership of over 20,000, in Washington, D. C.; prefer Diplomate or Board Eligible Physician; annual salary open; one month vacation; study leave; sick leave; comprehensive retirement plan; write to Medical Director, Group Health Assoc, Inc., 1025 Vermont Ave., N.W., Washington 5, D. C.

PRINTING and RECORDS

ASSOCIATE in General Practice Wanted—excellent office, housing, schools, and hospital facilities; early partnership; 25 miles northwest of Minneapolis. R. D. Thielen, M.D., St. Michael, Minnesota.

NEW MEXICO—Associate General Practice with Obstetrics-gynecology. Board eligible man; opportunity for future establishment small clinic; salary start; percentage after 6 months; beautiful year-round, sunny, dry, warm southwest city, 5000 feet elevation. Ray C. Bitterlich, M.D., 142 Truman Avenue, Albuquerque, New Mexico.

GENERAL PRACTITIONER; for Staff of Group Practice Clinic; serving membership of over 20,000, in Washington, D. C. Department heads and many other staff members have American Boards; prefer man with 2 years general internship and graduate of grade A Medical School; annual salary open; one month vacation; study leave; sick leave; comprehensive retirement plan; write to Medical Director, Group Health Assoc., Inc., 1025 Vermont Ave. N.W., Washington 5, D. C.

ASSOCIATE SPANISH SPEAKING physician wanted; only qualified need apply; New Jersey License required. J. R. Herradora, M.D., 2750 Boulevard, Jersey City, New Jersey.

WANTED—PSYCHIATRISTS: salary dependent upon experience and education; 3200 bed mental hospital, located near New Jersey shore resort area; 45 miles from New York City. Must be graduate of Grade A medical school; licensed or eligible for license in New Jersey; experience in this field essential. Address applications to: Medical Director, State Hospital, Marlboro, New Jersey.

STAFF POSITION AVAILABLE — Competent physician for full time employment in industrial dispensary of AEC contractor in the Southwest; previous experience in occupational medicine is not essential; this is a permanent position which offers opportunities for obtaining a working knowledge of nuclear medicine; there are attractive benefits; retirement plan, etc.; this is not a civil service position. Please address inquiries to: Dr. Sheldon Bliss, Staff Employment Section 582, Sandia Corp., Albuquerque, New Mexico.

STAFF PHYSICIAN and/or chief, physical medicine rehabilitation service for 250 bed tuberculosis hospital, 25 miles to Kansas City via four-lane highway; affiliated with University of Kansas Medical School; starting salaries range from $5915 to $11,610 annually, depending on qualifications. Excellent retirement system, 30 days paid vacation, and additional sick leave benefits. Experience and Board Certification in tuberculosis desired but not required. Citizenship required. Housekeeping quarters available at reasonable rental. Write Manager, Veterans Administration Hospital, Excelsior Springs, Missouri.

UNUSUAL OPPORTUNITY. American-born, Illinois-licensed full time physician to work with growing General Practice group. Association leading to partnership. No nights or Sundays. Available now. Norwood Medical Center, 7820 West Higgins Road, Chicago 31, Illinois.

TWO GENERAL PRACTITIONERS—To join 3 generalists and 12 visiting specialists in challenging program; excellent facilities, hospital affiliation; guaranteed $12,000 net. Raleigh-Bone Medical Group. Box 1023, Charleston, West Virginia.

PATHOLOGIST to direct clinical laboratory in 3000 bed psychiatric hospital, located 45 miles from N.Y.C., only 15 minutes from seashore resorts; approximately 150 autopsies performed yearly; require Board Diplomate license to practice in New Jersey; salary $10,200 with $600 yearly increments to $13,200. Apply—Medical Director, N. J. State Hospital, Marlboro, N. J.

OTOLARYNGOLOGIST wanted—Certified or eligible; to head department in 14 man clinic, all specialists; near Sacramento, California; married, military service completed; salary 1st year; early full partnership; send full details. John F. Hollister, M.D., Woodland Clinic Hospital, Woodland, California.

RESIDENCIES WANTED

GERMAN PHYSICIAN, 33 years, married, internship in Germany and 1 year Costa Rica partly with United Fruit Co.; 2 years in internal medicine and tropical diseases, diploma for tropical medicine (Tropeninstitut Hamburg), 1 year in pulmonary tuberculosis. Languages: German, French, Spanish, English; best references, looking for position as Resident for 1 year in USA (internal medicine). Offers including salary to Dr. H. Lieske, Hamburg-Sasel, Wegzoll 18, Germany.

RESIDENTS WANTED

TWO YEAR RESIDENCIES IN ANESTHESIOLOGY—approved by the American Board of Anesthesiology are available now; full maintenance and monthly stipend of $125 to $200. Send application to: Stevens J. Martin, M.D., St. Francis Hospital, Hartford 5, Conn.

GENERAL PRACTICE RESIDENCY—A two-year residency is offered at the University of Colorado Medical Center, with a choice of programs in the second year. Appointments are now being made for July 1, 1957. Apply to the Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Avenue, Denver 20, Colorado.

RESIDENTS WANTED

PSYCHIATRY—BARNES HOSPITAL; 3 Year Approval; versatile residency offering supervised dynamic psychotherapy, excellent opportunities for research training in neurology, recognized child guidance clinic, outpatient and inpatient therapy in new university psychiatric hospital, psychosomatic medicine closely allied with internal medicine; close liaison of university with psychoanalysts; St. Louis, a city with artistic intellectual facilities; program and salary flexible; full maintenance. Write: E. F. Gildea, M.D. Department of Neuropsychiatry, Washington University Medical School, St. Louis, Missouri.

PATHOLOGY RESIDENT—July 1957; 553 bed general hospital; active medical school affiliation and appointment. Apply: Richard G. McManus, M.D. Institute of Pathology, The Western Pennsylvania Hospital, Pittsburgh 24, Pennsylvania.

INTERNAL MEDICINE—Gastroenterology. Approved residencies in 3 year medicine and 1 year gastroenterology programs; affiliated with University of Oregon Medical School; salary $2840 to $3550. Apply Chief Medical Service, Veterans Administration Hospital, Portland, Oregon.

RADIOLOGY RESIDENCIES—Fully Approved 3 year residency including diagnostic therapy, radium and radioactive isotopes; teaching hospital with university connections; vacancy available January 1, 1957 and July 1, 1957. Address Director, Department of Radiology, Evanston Hospital, Evanston, Ill.

OPPORTUNITY FOR RESIDENCY training for a limited number of physicians starting January 1957 or July 1957. Accredited for two years training. For further information contact Jack A. Wolford, M.D.; Superintendent Hastings State Hospital, Ingleside, Nebraska.

FULLY APPROVED Obstetrics-Gynecology residency; 320 bed non-sectarian, non-profit hospital. California license or eligible. Apply: E. C. DeLear, Assistant Administrator, Saint Francis Memorial Hospital, 900 Hyde Street, San Francisco 9, California.

GENERAL PRACTICE RESIDENTS—Wanted for 220 bed County General Hospital 25 miles from San Francisco: Approved for G P by A M A; Excellent teaching program. $300 plus maintenance; J. Paul Sweeny, M.D., 210-39th Ave.; San Mateo, California.

FULLY APPROVED RESIDENCIES. Three years in Internal Medicine. Three years in Pathology. All teaching by Diplomates. Joint program of an educational and research foundation with an accredited hospital in a large Southwestern city. Apply to Box R 106, Resident Physician, 1447 Northern Blvd., Manhasset, New York.

PSYCHIATRIC RESIDENCIES—Indiana University Medical Center; are now available; fully-approved for 3 years of psychiatric training in a modern 2500 bed medical center; widely diversified training and experience provided in a 250 bed psychiatric treatment hospital, under Dr. D. F. Moore with rotating services through adjacent campus facilities, including 500 bed Veterans Administration hospital with Dr. E. J. Fogel, Chief of Neuropsychiatry, active university child guidance clinic and a university psychiatric outpatient clinic; ample opportunities for training and consultative services in a variety of university clinics and in 3 other university hospitals, including a children's hospital; broadly oriented university training program with close personal supervision of psychotherapy in clinics and hospitals; impressive interdepartmental opportunities for active clinical and allied basic research in a new psychiatric research institute and for teaching and supervisory experience in the medical school and its affiliated training programs in the social sciences; stipend for 1st year, $4380, increasing proportionately to 3rd year $5760; eligibility for state licensure required for appointment. Write: J. I. Nurnberger, M.D., Department of Psychiatry, Indiana University Medical Center, Indianapolis, Indiana.

RESIDENT HOUSE PHYSICIAN—wanted immediately—grand opportunity for young man who has just completed his internship or residency; general hospital, 154 beds and organized medical staff, 50 physicians; applications accepted for 1 year or longer as individual desires; starting salary $3,200 per annum; desirable opportunity with close association for medical profession of community; applicants from Exchange Visitor Program cannot be accepted. Apply: Matthew I. Barron, Director, Portland City Hospital, Portland, Maine. Interview granted at applicant's convenience.

APPROVED RESIDENCIES—VA Hospital, Houston, Texas, integrated training programs, Baylor University Affiliated Hospitals Residencies, Texas Medical Center. Applications accepted for Neurology, Anesthesiology, Pathology, Physiatry, Psychiatry, Radiology and Urology. "Career" residencies in Neurology, Psychiatry, Anesthesiology and Physiatry. Citizenship required. Manager, VA Hospital, or Dean, Baylor University College of Medicine.

PATHOLOGY RESIDENCIES—University of Kansas Medical School and VA Hospital; 4 year program available for certification, 1 year program for residents other specialties; 12 full time staff pathologists; U. S. citizens preferred. Apply: Dr. R. E. Stolwell, Kansas City 12, Kansas.

ANESTHESIOLOGY Residencies — At University of Minnesota Hospitals, Minneapolis Veterans Administration Hospitals and Associated Hospitals: An opening every 4 weeks. Address: Frederick H. Van Bergen, M.D. Director of Anesthesiology, University of Minnesota Hospital, Minneapolis, Minnesota.

LOS ANGELES AREA — PSYCHIATRIST VACANCIES in new Veterans Administration Hospital affiliated with 3 medical schools; opportunity for individual and group therapy and research; salary $8990 through $12,685 plus 25% specialty allowance. Contact: Manager, VAH, Sepulveda, California.

OFFICE SPACE AVAILABLE

ST. CLAIR, MISSOURI—eight room brick home; built 1952-56; easily converted to o..ce space and ample living quarters; $24,500, $4500 down. Complete description from: W. P. Eyberg, St. Clair, Missouri.

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ALL RESIDENTS:

To be certain you won't miss a single copy of RESIDENT PHYSICIAN, please notify us *at least 30 days in advance* of any change in your *hospital* mailing address. Simply drop a card to Resident Physician, 1447 Northern Blvd., Manhasset, N. Y. *Please state both old hospital and new hospital addresses,* your specialty, and the name of your chief of service.

RESIDENT RELAXER

(puzzle on page 15)

WHAT'S THE DOCTOR'S NAME?

(from page 98)

ALBERT SCHWEITZER

VIEWBOX DIAGNOSIS

(from page 17)

GOUT

Note replacement of bone by gouty deposits with extraosseous extrusions and associated soft tissue swelling.

"MEDIQUIZ" ANSWERS

(from page 100)

1(D), 2(B), 3(D), 4(D), 5(A), 6(A), 7(B), 8(D), 9(C), 10(C), 11(B), 12(A), 13(D), 14(B), 15 (C), 16(A), 17(B), 18(B), 19(D), 20(A), 21(C), 22(A), 23(C), 24 (B).

Annual Index

Volume I—Nos. 1 and 2 • Volume II—Nos. 1-12

SUBJECTS

BOARD REQUIREMENTS

EQUIPPING

ROUNDTABLES

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